Hearing on Protecting Americans with Pre-existing Conditions

HEARING

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HOUSE COMMITTEE ON WAYS & MEANS
CHAIRMAN RICHARD E. NEAL

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE CONTACT: (202) 225-3625

January 22, 2019

No. FC-2

Chairman Neal Announces a Hearing on Protecting Americans with Pre-Existing Conditions

House Ways and Means Committee Chairman Richard E. Neal today announced that the Committee will hold a hearing on Protecting Americans with Pre-Existing Conditions. The hearing will take place on Tuesday, January 29, 2019, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with

the formatting requirements listed below, **by the close of business on Tuesday, February 12, 2019.** For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you require special accommodations, please call (202) 225-3625 in advance of the event (four business days' notice is requested). Questions regarding special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at http://www.waysandmeans.house.gov/

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WITNESSES

Karen Pollitz
Senior Fellow, Kaiser Family Foundation
Witness Statement

Andrew Stolfi
Commissioner and Administrator of the Division of Financial Regulation, Oregon Division of Financial Regulation
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Keysha Brooks-Coley
Vice President, Federal Advocacy & Strategic Alliances, American Cancer Society
Witness statement

Andrew Blackshear
Patient and Volunteer, American Heart Association
Witness statement

Hearing on Protecting Americans with Pre-existing Conditions

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C

The committee met, pursuant to call, at 10:00 a.m., in Room 1100, Longworth House Office Building, Hon. Richard E. Neal [chairman of the committee] presiding.

Chairman Neal. The Ways and Means Committee will now come to order. I want to thank everyone for their presence here today for the Ways and Means Committee's first policy hearing in the 116th Congress. A warm welcome to the new members of the committee on both sides of the aisle. I am honored this morning to be the 67th chairman of the House Ways and Means Committee. We take this position, history, and prestige of the committee all quite seriously.

I look forward to considering policies that will have a positive impact on the future of our Nation and all American families. Today we will discuss an issue that affects nearly every American family: preexisting conditions and their impact on healthcare coverage. Over 130,000 Americans have a preexisting condition, and protecting them goes to the core of safeguarding healthcare for all Americans.

What insurance companies consider to be preexisting conditions can be anything from asthma to cancer to even pregnancy. Before the Affordable Care Act, which is the current law of the land, Americans faced significant hardship when trying to purchase adequate healthcare coverage. Insurance companies could refuse coverage altogether, charge excessive fees, and place dollar limits on the amount of care that Americans might

receive. Insurers could even discriminate against patients with common healthcare issues such as diabetes or high blood pressure.

When the ACA became law, new safeguards went into place to put a stop to these practices. Our healthcare system's protections really matter for American families, peace of mind, and certainly for their pocketbooks.

My colleagues on the other side from time to time have offered a different view. Despite their repeated claims to support the protections for healthcare with people in preexisting conditions, their actions have directly contradicted the statements. They are currently leading ongoing efforts to undermine or eliminate the current law's protections for Americans with preexisting conditions. This is the wrong course of action.

The Trump administration's efforts to chip away at the law and 18 Republican attorneys general who are actively trying to sabotage the law through the courts understand what they can't do legislatively they will attempt to do judicially. As one of the first actions in the 116th Congress, my colleagues and I are moved to intervene in the GOP lawsuit and defend the current law's preexisting conditions safeguards.

I am pleased to join attorneys general from Massachusetts and other Democratic attorneys general who are defending consumers in fighting for Americans with preexisting conditions. Let me be clear: The ongoing effort to sabotage the healthcare system is having a direct impact on the finances of Americans across the country, and it is creating uncertainty for one-fifth of the U.S. economy. Four million Americans have lost health insurance since President Trump took office. That is 4 million Americans who previously had insurance and now must pay their medical costs fully out-of-pocket or delay needed medical care. And earlier this month, this administration took action to reduce the tax credits by $900 million while raising the out-of-pocket maximums by an additional $400 per family.

I want to take a minute to share a story about one of my constituents who has been personally impacted by the preexisting condition protection. Michael Finn is 48 years old and a State representative from West Springfield, Massachusetts. He was diagnosed with type 2 diabetes 2 years ago when he was 46. He was a borderline diabetic for at least 10 years before that, even though his condition went undiagnosed.

Mike is married with three children under the age of 10, and he is grateful to the ACA for allowing him to keep receiving treatment, medication, and care, even though he has a preexisting condition. His wife is a stay-at-home mother, and Mike is the sole breadwinner in the household. If he were unable to work or unable to receive insurance assistance to help cover healthcare costs, he and his family don't know what they would do.

We need to embrace policies that protect people like Mike. The law is currently clear. But there is an opportunity to build upon it and stop the ongoing sabotage. I have seen in Massachusetts that we can work together across party lines to make sure Americans have coverage and to protect families from financial ruin. Recall that 100 percent of the children in Massachusetts are covered and 97 percent of the adults. We need more of that reflection here in Congress, and I hope this hearing will be the beginning of that process.

I am pleased our witnesses could join us today to share their professional and personal experiences and thoughts on how protections for people with preexisting conditions are essential. Our witnesses know that these safeguards can be the difference between getting needed medical assistance and foregoing necessary treatments or the difference between accessing affordable care and losing a lifetime of savings just to stay alive.

These protections mean the world to people, and they are the law of the land. I am glad we will have an opportunity this morning to discuss them.

And, with that, let me recognize the ranking member, Mr. Brady, for his opening statement. Mr. Brady for 5 minutes.

[The statement of Chairman Neal follows:]

Mr. Brady. Thank you, Chairman Neal, for convening this important hearing today.

Without question, while America's health system boasts remarkable innovation and highly trained professionals, it faces many challenges, the greatest among them: the high cost.

Americans agree. In a recent Gallup Poll, almost 70 percent of Americans say healthcare has major problems, and nearly that many say rising insurance premiums are their biggest concern. It is clear the status quo of America's healthcare isn't working. When Democrats pushed through a healthcare bill, written behind a closed door, filled with special interest provisions, and with no Republican support, President Obama made many unkept promises to the American people, including the reform we are proposing will provide you more stability and more security. When it comes to healthcare costs, the words "stability" and "security" are the last to come to mind.

It has been 10 years since the ACA was passed by Democrats only, and yet healthcare still remains the top worry of American workers and businesses. We have to do better. For Republicans, what we hope will happen today is an honest conversation, one on how we can create a healthcare system that is more compassionate, more convenient, and less costly.

And to begin, there are a few things that I would like to make clear. First is this: Of course, Republicans support protections for people with preexisting conditions. We included these protections in our House-approved alternative to the ACA. Section 137 of the American Healthcare Act said clearly: Nothing in this Act shall be construed as permitting healthcare insurance issuers to limit access to health coverage for individuals with preexisting conditions.

Furthermore, Republicans guaranteed there can be no lifetime limits on healthcare

costs. It is important if you have a child with an expensive disease or you face one yourself. We make sure young people can stay on their parents plan until they are age 26. And then again, on day one of this Congress, Republicans offered and unanimously supported an amendment on the House floor stating our unwavering support for protecting patients with preexisting conditions. This means guaranteeing no American purchasing healthcare as an individual can be denied coverage, denied renewal, or charged more because they have a preexisting condition.

These protections, by the way, have long been guaranteed for 93 percent of the Americans who get their healthcare at work or through the government. They should be guaranteed for individuals as well. And if you remember only one thing we say today, remember this: We have to do more than protect healthcare; we have to work together to make it affordable. The ACA is failing too many Americans who face soaring costs, skyrocketing deductibles, and few choices of local doctors and hospitals. It really is time for a fresh start, this time with both parties working together creating truly affordable healthcare focused on patients, not on Washington.

This committee advanced many bipartisan healthcare reforms last Congress that expanded health savings vehicles for families, protected the most fragile among us in Medicare, rolled back some of ObamaCare's most egregious taxes, and looked for ways to increase innovation. So let's work together this Congress to build on these initiatives.

I think there are many commonsense areas where we can work together, Mr. Chairman, from price transparency, spurring innovation, lowering drug prices, addressing surprise billings, and removing the regulatory barriers to improve patient care.

The final point I would like to make is this: What Republicans don't support, as well as the majority of Americans, is the status quo. I know many of my Democrat colleagues may want to relitigate the past today; we will be glad to because the ACA has

become too expensive to use for so many Americans and so many Texans. So expensive, in fact, twice as many Americans have found a way to get out of ObamaCare than those who chose it. Twice as many got out of it -- out from under it because they couldn't afford it and they couldn't use it.

So what will benefit us is to focus on the future. Today let's turn a new leaf, beginning the work folks back home sent us here to do: work together to help make healthcare less expensive and easier to use. We owe that to our families and to our businesses.

With that, thank you, Chairman Neal.

[The statement of Mr. Brady follows:]

Chairman Neal. Thank you, Mr. Brady.

And, without objection, all members' openings statements will be made part of the record.

Let me now introduce our distinguished panel of witnesses for the opportunity to discuss many of the important questions for protecting coverage for preexisting conditions.

First, I would like to welcome Karen Pollitz, a senior fellow at the Kaiser Family Foundation and, for those of you with long memories, a former staffer for our longtime colleague Mr. Levin of Michigan, who recently retired from Congress.

Next is Andrew Stolfi. He is the insurance commissioner from my friend Earl Blumenauer's State, Oregon. He is in the Oregon Division of Financial Regulation.

Rob Robertson from the State of Adrian Smith's, Nebraska. He is the chief administrator, secretary-treasurer of the Nebraska Farm Bureau.

Keysha Brooks-Coley, vice president for the Federal Advocacy and Strategic Alliances at the American Cancer Society, will share with us why these protections are so critical for Americans living with cancer and cancer survivors.

And, finally, Andrew Blackshear, a constituent of Mr. Thompson and one of the 133 million Americans with a preexisting condition. His story highlights the dangers of short-term limited-duration healthcare plans that have been promoted by the Trump administration.

Each of your statements will be made part of the record in its entirety. I would ask that you summarize your testimony in 5 minutes or less. And to help you with that time, there is a timing light that you might take note of at your table. When you have 1 minute left, the light will switch from green to yellow and then finally to red when the 5 minutes are up.

Ms. Pollitz, please begin.

STATEMENT OF KAREN POLLITZ, SENIOR FELLOW, KAISER FAMILY FOUNDATION

Ms. Pollitz. Thank you, Mr. Chairman, and Ranking Member Brady, and members of the committee. Good morning.

Mr. Chairman, most people are healthy most of the time, but when we need care, it can get expensive. Figure 1 in my statement shows that each year about 20 percent of people account for 80 percent of all health spending, while the healthiest half accounts for just 3 percent of health spending. That chart is just a snapshot, though. Over time, our health status changes, and eventually, at some point, we will all get sick or hurt or pregnant and need costly care at least for a while. So we buy health insurance in case we get sick, not in case we stay healthy.

Before the Affordable Care Act, the individual insurance market didn't always work for people once they got sick. People with preexisting conditions could be turned down or charged more. About 27 percent of nonelderly adults each year have a condition, such as cancer, diabetes, or pregnancy, that would have made them uninsurable in this market.

Also, people healthy enough to get nongroup coverage couldn't be sure it would work for them once they got sick. Policies typically didn't cover key benefits, such as prescription, drugs, mental health, or maternity care. And if people made large claims, they could find it hard to stay covered. Renewal premiums could skyrocket. Insurers also engaged in post claims underwriting, investigating a condition to see if it existed even undiagnosed before the policy, and if so, denying claims for the preexisting condition.

Premiums on average were cheaper before the ACA. But there was a lot of

variation around that average. And the cheapest premiums were only available to people while they were young and healthy. The ACA made a lot of changes. It required insurers to take everybody and offer policies that cover essential health benefits at premiums that don't vary based on health status. To make that affordable, the ACA added subsidies. Last year, more than 9 million people bought nongroup policies with the help of premium tax credits.

Subsidies also stabilize the market, helping people buy regardless of health status, and they effectively absorb premium increases from year to year for people who are eligible. Of course, nearly 4 million other unsubsidized individuals were enrolled in ACA policies last year, mostly bought outside of the marketplace. And, for them, rising premiums are harder to afford and enrollment by unsubsidized individuals has been declining.

Why are premiums rising? Uncertainty is the key underlying reason. Insurers didn't know how to price for this in market when it opened. Most set premiums low and lost money in the first 3 years. Rates then increased substantially in 2017, a one-time correction, according to insurer rate filings, but then new sources of uncertainty arose.

The Trump administration ended payments to insurers for cost-sharing subsidies they are required to provide through the marketplace. Insurers responded with so-called silver loading, raising the premiums for silver plans twice as much in 2018 as for bronze and gold plans. For 2019, for the first time we saw national average premiums for the benchmark marketplace plan decline by about 1 percent. Even so, premiums this year are higher than they would have been by about 6 percent due to two new factors: repeal of the ACA individual mandate penalty and competition from short-term policies.

Short-term policies are exempt from ACA market rules. They will deny coverage to people who are sick. They will terminate coverage for people when they get sick.

And typically they covered fewer benefits. They are also cheaper, but only for healthy people. Competition by short-term plans threatens stability of the ACA risk pool. Initially that threat was limited because regulations required the term of short-term policies to be short, less than 3 months; they weren't eligible for subsidies; and they didn't satisfy my mandate, so people who bought these to save money were at risk owing a tax penalty.

But now the mandate penalty is gone. The new Trump administration regulations allow short-term policies to last up to 12 months. And other guidance on ACA waivers now give States a path to promote the sale of these policies and even shift some Federal subsidy dollars to them.

How markets might evolve under these and other changes remains to be scene. Further steps to divide the risk pool can make cheaper options available to some people while they are healthy, but that strategy won't increase choices for people who have health conditions, and it will increase premiums for the ACA-compliant plans on which they rely.

Protections for people with preexisting conditions have become a defining feature of the ACA, and they enjoy strong public support, our polling shows, by Democrats and Republicans, and by people with preexisting conditions, and those who haven't developed them yet. Most Americans want health insurance to work for people when they get sick.

Thank you, and I am happy to take your questions.

[The statement of Ms. Pollitz follows:]

Chairman Neal. Thank you, Ms. Pollitz.

Now we would like to recognize Mr. Stolfi. Would you please begin?

STATEMENT OF ANDREW STOLFI, COMMISSIONER AND ADMINISTRATOR OF THE DIVISION OF FINANCIAL REGULATION, OREGON DIVISION OF FINANCIAL REGULATION

Mr. Stolfi. Chairman Neal, Ranking Member Brady, members of the committee, thank you for inviting me today for this important discussion. My name is Andrew Stolfi, and I am the insurance commissioner and administrator of the Oregon Division of Financial Regulation.

Since Oregon implemented the major provisions of the Affordable Care Act, more than 340,000 Oregonians have gained health insurance, and our uninsured rate has dropped from a high of more than 17 percent to about 6 percent. Today more than 3.7 million Oregonians, 94 percent of the State, are covered by health insurance, and our goal is to maintain coverage for 99 percent of adults and 100 percent of children.

Governor Brown's vision and our goal is not just a number; it is for all Oregonians to have quality, affordable healthcare, regardless of who they are or where they live. The ACA has greatly advanced this goal, and we urge this Congress to protect the gains that have been made while continuing to work towards bending the cost curve for consumers.

Oregon's health insurance market has traditionally been competitive and offered choice. We have also been a leader in implementing progressive consumer-focused health reforms. However, despite our best efforts, our uninsured rate in 2009 was higher than the national average at more than 17 percent. Oregonians seeking insurance in the individual market also experienced high rates of denials based on preexisting conditions. In 2007,

the denial rate was about 30 percent.

And when an individual policy was issued, it could exclude or limit coverage in a myriad of ways. The ACA helped change all of this, particularly for those with preexisting conditions. More than 1.6 American Oregonians with preexisting medical conditions are protected from coverage denials or limitations. Pregnant mothers know they can get the care they and their babies need. And children with developmental disabilities can get all the essential therapy they need to grow to their fullest potential.

We have individual health policies offered by at least two carriers in each of our counties and are one of the first States to implement our reinsurance program that has kept individual insurance rates about 6 percent lower than they would be without. These numbers reflect the work that has been done in Oregon to provide stability to the State's health insurance market. Unfortunately, other numbers demonstrate the harm recent Federal actions have caused.

Federal rule changes to short-term limited-duration plans and association health plans, along with zeroing out of the individual mandate penalty have raised 2019's individual health insurance rates about 7 percent. Cutting off funding for cost-sharing reductions has added another 7 percent to 2019 silver rate plans, meaning that Oregon -- rates in Oregon in 2019 are between 7 and 14 percent higher than they could have been without unnecessary and avoidable Federal uncertainty.

The true harm, however, would come if challenges to the ACA were successful and we lost the consumer protections it created for people with preexisting conditions. These protections require a comprehensive set of interlocking laws that work together like spokes in a wheel. For an individual with a preexisting condition, these spokes fit together like this: Guaranteed issue lets you buy a policy you need. Community rating prevents you from being charged more just because of your condition. Guaranteed renewability

prevents an insurer from canceling your policy if you use its benefits. A ban on preexisting condition exclusions ensures that your policy covers the treatment you need. Preventive services can keep your problem from getting worse. Essential health benefits ensure that all the treatments you need are covered, and a ban on annual and lifetime dollar limits protects you from crippling out-of-pocket expenses when you use your essential benefits.

Oregon's experience pre-ACA shows why each of these elements are essential and work together to protect individuals with preexisting conditions. In 2009, we technically had some protections for individuals with preexisting conditions, however, within these meager protections, insurers had ample room to limit their risk exposure and control costs.

A pregnant woman could be denied coverage. Treatment for a preexisting condition could be limited. Miniscule benefit limitations could be imposed, and necessary prescription drugs were not required to be covered. For those with preexisting conditions, you were lucky if you are even given the choice to take an insurer's limited terms.

In conclusion, the ACA has helped to provide Oregonians and their families with access to comprehensive healthcare. It has greatly reduced our uninsured population, created tens of thousands of new jobs, and saved hospitals hundreds of millions a year in uncompensated care. More people are healthier than they would be without it.

Unfortunately, uncertainty at the Federal level has threatened our work and unnecessarily added cost to the system. Access to affordable healthcare is important for everyone, and it is time we stop dismantling the gains we have made and focus more on innovative solutions to control cost and maintain a stable health insurance market.

Under Governor Brown's leadership, we will continue to protect consumer's access to healthcare through the ACA. We will continue to build on our successes, fight to increase access, and search for ways to make insurance affordable for everyone.

[The statement of Mr. Stolfi follows:]

Chairman Neal. Thank you.

Now I would like to recognize Mr. Robertson. Please, begin.

STATEMENT OF ROB ROBERTSON, CHIEF ADMINISTRATOR/SECRETARY-TREASURER, NEBRASKA FARM BUREAU ASSOCIATION

Mr. Robertson. Yes, good morning, Congressman Neal, Congressman Brady, and members of the Ways and Means Committee. I am Rob Robertson, chief administrator for the Nebraska Farm Bureau. We are pleased today to share with you some challenges we see in the individual health insurance markets and also some steps that Nebraska Farm Bureau took to protect those Americans with preexisting conditions.

I have dedicated my entire life to help farmers and ranchers, and I just honestly couldn't belief what I saw during the summer of 2018. We held listening sessions with our farmer and rancher members, and literally they got up in tears talking about their challenges of how they are coping with the health insurance markets and the individual market. And the emotional stories were many. I mean, farmers and ranchers and spouses got up and said, you know, I am forced to work off the farm because of the high cost of health insurance.

Farm and ranch families not taking out any health insurance and then having major medical bills during the year. Highest living expense for the farm is health insurance. Those stories were all over the board. We heard common reports of annual premiums being $30,000 to $35,000 to $36,000 a year. That is $3,000 a month. And I am sure Congress Adrian Smith heard similar stories throughout his travels in Nebraska as well.

But what makes matters worse is farmers and ranchers, more than any other sector

or occupation in the country, are more affected by the high cost of the individual health insurance markets than any other sector because the lion's share of farmers and ranchers are self-employed. And if you are self-employed, you generally buy on the individual market where the costs are high and you are not able to be a part of a large group. This is not a partisan issue. This is not a political issue. This is an issue of hardship. And we need to fix these individual markets and try to find some ways to protect preexisting conditions at the same time.

Because of these issues with our members, the Nebraska Farm Bureau took matters in our own hands. In 2017, we began to establish an association health plan with our organization. By the fall of 2018, we implemented and started enrollment. It never would have happened without the wonderful partnership we had with the insurance carrier Medica, based out of Minneapolis, Minnesota. They partnered with us, and the plan offered a more affordable health insurance product, which on average was 25 percent less than the individual marketplace for members of our large group in our association health plan. It covers preexisting conditions. And let me repeat that: It covers all members regardless of their health status in our association health plan. And it was ACA compliant.

The plan is what our members wanted and is what we delivered. In creating the association health plan, we deeply believed it was imperative to cover preexisting conditions, and that is what we did. Let me be clear: That is not an attack on the ACA; that is a companion to the ACA by providing our members with another insurance option.

And our results: Coming out of the first year, we had almost 700 members sign up for the association health plan; they saved millions of dollars in premium costs; and then we continue to hear a lot of interest this coming year for sign-up for the next enrollment period, starting 2019 for the 2020 year. From a policy standpoint, one of the best ways we

can do to protect Americans with preexisting conditions is to enhance the ability of individuals to ban together, pull their risk, and form large groups that are fully insured. That is what the AHP, our association health plan, did.

In our case, many of our members are self-employed. The only way we are going to be able to form this association health plan was because of the new association health plan regulation issued by the Department of Labor last summer. If it wasn't for those new regulations, we would not have an association health plan for our members.

Let me share a quick example with you on the impact this association health plan had with members. Our first enrollee out of the gate, a husband and wife who farms together near Fairbury, Nebraska, in 2018, their annual cost on the individual market was $25,000. They are told in 2019 it was going to be $26,000 a year. Under our plan in which they signed up, it was $19,000. They saved $7,000, and that is real money.

How do we get this discounted rate? You know, farmers and ranchers are now a part of a large group, rated as a large group. And when you rate as a large group, you can spread the risk out, you can lower administrative costs, and you can do a little bit more with pricing in terms of risk-adjustment factors.

My testimony provides a lot of eligibility criteria on how to be a part of our association health plan. In general, you have to be in a similar line of business to be a part of that, so we designated and targeted farmers and ranchers and agribusinesses, and it is ACA-compliant on what it covers.

Our organization represents farmers and ranchers with an average age approaching 60. We strongly support the continuation of health plans that cover preexisting conditions. The key is to provide innovative policy solutions to allow for those types of things like the association health plans to be a part of how we cover preexisting conditions. Hopefully, our plan works. And I appreciate the time from the committee today, and I

will be happy to answer any questions.

[The statement of Mr. Robertson follows:]

Chairman Neal. Thank you, Mr. Robertson.

Let the chair recognize Ms. Brooks-Coley. Please, begin.

STATEMENT OF KEYSHA BROOKS-COLEY, VICE PRESIDENT, FEDERAL ADVOCACY & STRATEGIC ALLIANCES, AMERICAN CANCER SOCIETY

Ms. Brooks-Coley. Good morning, Chairman Neal, Ranking Member Brady, and members of the committee. I am Keysha Brooks-Coley, vice president of Federal Advocacy for the American Cancer Society, Cancer Action Network, the nonpartisan, nonprofit advocacy affiliate of the American Cancer Society.

We appreciate the committee holding today's hearing to examine how policymakers can build on critical patient protections in the ACA and make sure people continue to have access to quality, affordable health insurance. Nearly 16 million Americans have a history of cancer and another 1.8 million will be diagnosed with the disease this year. For these individuals, your family, friends, and many of your constituents, access to affordable health insurance is a matter of life and death.

The American Cancer Society research shows that uninsured Americans are less likely to get screened for cancer and more likely to be diagnosed at an advanced stage. Yet, prior to the ACA, a cancer diagnosis or other serious illness was often the exact reason why these individuals were uninsured. Insurance companies could deny coverage to someone simply because they had or had survived cancer. They could abruptly revoke health coverage after someone was diagnosed. They could charge exorbitantly high premiums to purchase coverage. In other words, people who needed health coverage the most could not get it.

Before the enactment of the ACA, the American Cancer Society's national call

center heard from recently diagnosed cancer patients daily who were unable to get coverage because of their disease or who had lost coverage as a result of their diagnosis. It was stories like these about cancer patients from across the country that moved ACS CAN and other advocacy organizations to engage in the policy debate about access to care. Passage of the ACA significantly helped cancer patients and others with serious conditions.

People can no longer be denied coverage because of a preexisting condition. They no longer face arbitrary lifetime or annual caps on their cancer care. And more Americans are able to access meaningful health coverage, either through marketplace plans, which currently serve 10 million people, or through Medicaid expansion, which currently provides coverage to 17 million people.

These patient protections are at the core of the ACA and must be maintained. Unfortunately, recent policy changes are putting many of these most essential protections at risk, specifically the expansion of short-term health plans and the drastic reduction in navigator funding. Last year, the administration is issued a final rule to expand access to short-term limited-duration health insurance. These plans do not have to abide by key consumer protections, they can discriminate based on preexisting conditions, charge higher premiums to sick people, and exclude certain benefits based on health history. This means they could cover everything except cancer care.

Expansion of these plans does not help consumers; it puts them at increased risk. While these plans are often touted as lower cost alternatives, they are only less expensive upfront because they don't cover necessary care.

Finally, ACS CAN is concerned about the drastic reductions that had been made to navigator and enrollment education funding. Shortened enrollment periods, fewer resources for outreach and education, and less funding for consumer navigators directly

impacts the number of individuals who enroll in marketplace coverage.

Beyond shoring up existing patient protections, there are also ways Congress can strength the ACA, many of which I detail in my written testimony, but a few I will mention now. Fixing the so-called family glitch would allow more families the opportunity to access affordable comprehensive healthcare. Eliminating the so-called subsidy cliff by creating partial subsidies for individuals with incomes above 400 percent of the Federal poverty level would also go a long way to improve affordability of coverage.

Mr. Chairman, thank you again for the opportunity to testify today. We urge the committee to find bipartisan solutions that ensure individuals with preexisting conditions are protected from discrimination, that essential health benefits are maintained, and that coverage is made affordable for individuals.

We look forward to working with you to build upon the foundation of the ACA and strengthen healthcare coverage for millions of Americans living with a serious illness such as cancer. Thank you.

[The statement of Ms. Brooks-Coley follows:]

Chairman Neal. Thank you, Ms. Brooks-Coley.

Mr. Blackshear, you are recognized, would you please begin.

STATEMENT OF ANDREW BLACKSHEAR, PATIENT AND VOLUNTEER, AMERICAN HEART ASSOCIATION

Mr. Blackshear. Chairman Neal, Ranking Member Brady, members of the committee, my name is Andrew Blackshear. I have been a volunteer with the American Heart Association since 2017. Thank you for the opportunity to testify today about the lifesaving importance of quality, affordable insurance coverage for people with preexisting conditions.

I was a healthy 27-year-old in 2015 when my health took a turn for the worse. I was at home after a long night of restaurant work, and as I leaned over to untie my shoes, I felt some chest pain. The pain continued the next day, and I came down with a severe fever. My fever kept climbing over the next few days, eventually going above 103 degrees, all the way up to 103.6.

I was worried I would lose my job if I didn't get back to work. So, on my first night back, I collapsed on the floor of the restaurant in response to a fluid buildup in between my heart and the pericardium, the sac that surrounds the heart, a condition later that I learned was called cardiac tamponade. The fluid buildup was making it much harder for my heart to do its job. I didn't know it at the time, but I learned later that I had contracted an infectious fungal disease while driving through California's San Joaquin Valley in August weeks before this.

The condition known as Valley Fever was caused by inhaling fungal spores that are released from the dry soil. It was likely that just by breathing the air coming through my

car vents had infected my lungs. When the spores disseminated through my lung tissue, I developed fungal pericarditis, and it almost took my life.

Treating my condition was a huge challenge. Over the next few weeks, my blood test and symptoms only got worse. Soon I needed emergency open heart surgery to remove the fluid around my heart. While fighting for my health, I was also fighting for the care that I needed. I had purchased a short-term health insurance plan after aging out of my parents' plan when I turned 27.

Shortly after the fungal infection was diagnosed, medical bills started piling up. I knew my short-term plan had a high deductible, so during the time of my echocardiogram, I paid the $5,000 deductible. But then I started receiving letters from the insurance company asking me for more about information and demanding that I prove my heart problems weren't caused by a preexisting condition. I kept getting the same letter over and over saying the insurance company wouldn't pay my nearly $200,000 in medical bills until I could show them that I didn't have a preexisting condition.

Still recovering from my first operation, I had to go to every doctor I had ever seen, all the way back to a pediatrician, to collect the information my insurer was demanding. The company finally agreed to pay for my care after I requested the State of California to help me take them to court. When open enrollment began in November of that year, it was amazing. I enrolled in a plan, started paying my premiums, and continued to see my same doctors, but there was a big difference. My ACA plan did what it was supposed to do: It paid for my doctors' bills instead of punishing me for being sick. No more calling around to my old doctors' offices. No more collecting and sending in paperwork to this company. And no more anxiety for my family over whether I could afford to get better.

Weeks after my first operation, I then had a tender stomach, extreme fatigue, swollen ankles, and trouble breathing. I flew to Minnesota to be tried at the Mayo Clinic

and was diagnosed with constrictive pericarditis and heart failure. My left and right ventricles were failing. I underwent my second open heart surgery to remove the sac around my heart completely. This is called a pericardiectomy.

I felt so much better after the second surgery. And with comprehensive coverage, I knew I wouldn't be bankrupted because I had gotten sick. Thanks to the Affordable Care Act, today I have no medical debt and I am healthy. But I will always be without a pericardium, so having health insurance that covers a preexisting condition remains a necessity to me.

As a heart disease patient and volunteer with the Heart Association, I urge lawmakers to make sure preexisting conditions are covered. No one should face the prospect of being unable to afford the care that they need to stay alive. Thank you again for focusing on this critical issue.

[The statement of Mr. Blackshear follows:]

Chairman Neal. Thank you for that very important powerful testimony, Mr. Blackshear.

We will now proceed under the 5-minute rule with questions for our witnesses. I will begin by recognizing myself for 5 minutes. But before asking the witnesses my questions, I would like at this time to yield 2 minutes to our colleague, Representative Gwen Moore, who I believe -- for the purpose of outlining her own experience, but most importantly, for the first time having done this publicly, for her constituency.

Ms. Moore, you are recognized for 2 minutes.

Ms. Moore. Thank you so much, Mr. Chairman. And I am so glad to be here. And when I say that I am glad to be here, I mean I am glad to be here. Literally, instead of yielding me time, you could be delivering kind words at my memorial service.

In the spring of 2018, I joined an exclusive club of millions of Americans with the cursed C-disease: cancer. A disaster that guarantees discrimination in the insurance marketplace; for many, a death sentence. Specifically, I have been discussed with small cell lymphocytic lymphoma, a manageable cancer with proper surveillance and treatment.

Right now I am in great health with an excellent prognosis of living with this disease, but throughout the spring and summer of 2018, I spent a lot of time on a gratitude tour of being grateful for medical research, having insurance, and, most importantly, thanking God for the ACA provisions. No, I am not one of the 20 million low-income people that we are going to lay down our lives to protect, but I am one of the people that, before the ACA provisions, I could have been subject to medical underwriting instead of community rating, making it unaffordable, no coverage of essential health benefits. And all the labs that I went to and visits to try to pin down this diagnosis depending on early intervention, none of that could have happened if they had imposed lifetime limits on my care and not -- and imposed caps on the out-of-pocket costs, the ACA imposed caps on

that. Worse, they could have just denied me completely because of my preexisting condition.

We have talked a lot about this costing too much or being too expensive. What does a life cost? Let me just say that I pay $15,000 a month for medicine. Who can afford that? And what am I worth?

I yield back.

[The statement of Ms. Moore follows:]

Chairman Neal. Thank you very much for that important testimony. I think your story highlights how, in considering how to strengthen and protect consumer protections for Americans with preexisting conditions, we must stand in the shoes of those facing hard decisions about their healthcare and work to make sure that they know their health insurance will be there when they need it and for what they need.

Now, let me return to the start of our questioning to the story I shared in my opening statement because each of us knows someone who had delayed getting healthcare only to be diagnosed with a chronic condition. Mike and his family benefit every day from the ACA.

Ms. Pollitz, before the ACA, what would have happened to the likelihood of Mike Finn and his family being able to get and keep an insurance plan that meets the needs of a diabetic as well as three young children? What kind of obstacles would they have faced in trying to get meaningful affordable care?

Ms. Pollitz. Mr. Chairman, diabetes is one of the conditions that, through our research, we demonstrated was a declinable preexisting condition. So the individual market would not have been an option for that family or at least for the child with diabetes, with the exception of a few States before the ACA that required, including Massachusetts, that required coverage to be offered on a guarantee issue basis. And so that was the largest barrier to getting coverage in a nongroup market.

In other plans, before the ACA, there could be temporary preexisting condition exclusion periods. So if you took a new job with a new health plan, there might be a waiting period as long as a year before the diabetes would be covered. Under a prior Federal law, HIPAA, people did have to get credit for prior coverage under other plans, so that when they switched jobs, they wouldn't continuously incur new preexisting waiting periods, but any break in coverage of 2 months or longer would end that protection, and

then people might again face job lock or difficulty getting private insurance coverage for a preexisting condition.

Chairman Neal. Thank you, Ms. Pollitz.

Ms. Brooks-Coley, I am sure that patients that you have represented have experienced with high-risk pools, can you please share your thoughts about patient experiences with high-risk pools?

Ms. Brooks-Coley. Thank you, Mr. Chairman.

An individual who has cancer has -- they have experienced issues with high-risk pools. Some of the concerns that patients have experienced is not having access to actual services that they need, making sure they have access to preventable screenings that we know that are lifesaving. Making sure that individuals have access to actually real coverage that they need that is not too expensive, and it is available when they need it.

We know that high-risk pools are not always the most comprehensive coverage, especially if you have a serious illness, such as cancer, and need access to very costly treatments as well as therapies.

Chairman Neal. Thank you.

And, with that, let me recognize the ranking member, Mr. Brady, for 5 minutes.

Mr. Brady. Mr. Chairman, thank you.

And thank you to each of the witnesses for your compelling testimony. Your belief and support for preexisting conditions is one of the reasons why Republicans fully support these preexisting conditions and no lifetime caps and making sure you can't be denied coverage and making sure young people can stay on their parents' plans. All that is critical.

But we have to do more than just protect preexisting conditions; we have to make healthcare more affordable. In Texas, I cannot tell you how many of my constituents tell

me they can't afford the ACA. The monthly costs are far too high. And, secondly, the out-of-pocket cost -- it can be $10,000. Who can use that healthcare insurance? And then often they can't even see their local doctor or go to the local hospital.

I am so glad that the Cancer Society is here because, in Houston, you know, maybe this is one of the reasons, you know, three Texans eligible for ObamaCare got out from under it, rejected it, for everyone that uses it. We have very few choices. Cost went down. That is the good news. But in the Houston region, for example, if you are a mom in Conroe, Texas, struck with breast cancer, if you are a father with prostate cancer, if you are someone with a blood cancer in Huntsville, we have MD Anderson Cancer Center, one of the finest cancer centers in the world. You can't go there if you're on ACA -- if you have a private plan, you can. If you are on the ACA, you've got to settle for less. Even if you can see MD Anderson, the best cancer doctors in the world for you, you are denied coverage under the ACA.

I am convinced we can do better to make healthcare more affordable and have access that patients need. I do believe that the Trump administration made some key moves over the last year, that have been almost a lifeline for some Americans who can't afford the Affordable Care Act. One is, for the first time, the average benchmark premium for the nearly 40 States that use Healthcare.gov, instead of doubling since ObamaCare came in place, for the first time ever, those rates decreased, including those in our State of Texas, where rates are down 2 percent. Decreased. Decreased.

Secondly, we now have, and I am pleased to say, we are actually starting to see more insurers and more choices in our State than before because, in too many counties in America, it was take it or leave it. You take that ACA plan or nothing at all, and that is not fair.

And then, when the individual mandate penalty was repealed, I think Speaker

Pelosi predicted millions of Americans would face lifesaving choices, but in truth, nearly 97 percent of those on the ACA have re-enrolled. The biggest challenge we face -- one of the reasons in Oregon two out of three people eligible for ObamaCare aren't signing up -- is the cost, and that is what I worry about the most.

Mr. Robertson, you were very careful in not criticizing the Affordable Care Act, and I think that is a great approach here. But what I heard you say was that these association plans and what you have developed for your members is because you can't afford the other ACA options available, and you had to find a better approach. As we think about the future of healthcare for the 7 percent of the Americans we are focused on here that don't get it at work or government, do you consider this, what you have for your members, to be junk plans or something inferior, or something that really meets the needs of your members?

Mr. Robertson. It is the latter. It really meets the needs of our members. And think about it: Everybody -- most people in this room probably are part of an employer group, but if you are an individual self-employed farmer or rancher, you are not. So the association health plans allow you to form a bonafide large group, which allows you to spread out the risk. We are in this for the long term because we want to reduce costs because the cost from the ACA in the individual market, when you are there solely, is very, very high.

Mr. Brady. You know, if I recall, was Nebraska one of the States that the ACA also created co-ops, you know, in healthcare to try to lower costs by sort of taking the public option? But if I recall, in many States, those co-ops failed and left a lot of Nebraskans and others in a real lurch. Did that contribute to the need to find something that actually works for your members?

Mr. Robertson. Yeah, absolutely. Two or 3 years ago there were a lot of co-ops

that formed. A couple of them, they all were going great guns the first year out, and then year 2 and 3, they all went belly-up, and that left many of our Nebraskans, particular farmers and ranchers, searching for the right policies and affordable policies, which there are hardly any.

Mr. Brady. Thank you, Mr. Robertson.

Chairman Neal. Thank you, Mr. Robertson.

With that, let me recognize the gentleman from Georgia, Mr. Lewis, for 5 minutes.

Mr. Lewis. Thank you, Mr. Chairman, for holding this hearing. As I said to you, I think this is a good place to start. Healthcare is a right; it is not a privilege. And all of us -- all Americans have a right to quality healthcare. I want to thank our colleague and friend, Gwen Moore, for sharing her story. It is not easy.

Mr. Blackshear, thank you for sharing your story with us. It must be difficult to come and testify in public about such a difficult and personal experience. I think you are very brave. Please may you share more about how you felt when you learned that your insurance would not protect you?

Mr. Blackshear. Yes. Thank you for the compliments as well. I was very worried. My whole family was worried. You know, these bills were stacking up. I knew I never had a heart problem. Everybody in my family knew I never had a heart problem. So I knew their attack wasn't justified at all, but I continued to jump through the hoops until I found a way out by finding someone from the State to fight for me. Just a lot of anxiety built up in my family while I was sick over these bills.

Mr. Lewis. But it is good that you didn't give up.

Mr. Blackshear. No, never.

Mr. Lewis. You didn't give in.

Mr. Blackshear. No, never.

Mr. Lewis. You kept the faith.

Mr. Blackshear. Uh-huh.

Mr. Lewis. You kept fighting.

Mr. Blackshear. Kept fighting.

Mr. Lewis. What would you say to others that may share your concern and conditions?

Mr. Blackshear. Yeah, to them personally, I would say: You know, if you are in that type of situation, keep fighting for what you deserve, you know. And another thing, I don't even think we should be in a position where we have to fight in those situations.

Mr. Lewis. Thank you, Mr. Chairman.

I yield back.

Chairman Neal. Thank you, Mr. Lewis.

With that, let me recognize the gentleman from California for 5 minutes, Mr. Nunes.

Mr. Nunes. Thank you, Mr. Chairman.

I want to thank all the witnesses here for testifying. And I want to make sure that everyone knows that everyone up here supports protections for preexisting conditions, always have, always will. Nobody up here believes that insurance companies should be able to jerk customers around, drop their coverage, and charge more when they get sick.

It is really this long debate in ObamaCare that Democrats have consistently used protections for people with preexisting conditions as a justification for the law and the creation of two new entitlement programs. They have $750 billion in Medicare cuts with ObamaCare, and a trillion dollars in tax increases.

ObamaCare was supposed to solve these problems, but in fact, has, in most cases, made it worse. So I understand we have a political theater here in Washington and have

hearings like this, but I think we should be careful so that we are not stoking fear that someone is going to lose their insurance. We really have a responsibility to come up with a better healthcare system because ObamaCare wasn't the solution.

Republicans have put solutions on the table in the past, and we will continue to do that. I would love to work with my colleagues on finding ways to fix our healthcare system. For example, we know that the Medicare trust fund begins to go broke just after 2020. 2024 is what they say today; it could be even sooner than that. So we have a lot of challenges ahead of us, and hopefully we can work together. And I think what it takes first is to admit that ObamaCare was not the solution. Maybe there is a better solution, but right now, it is not the solution.

Mr. Robertson one of the things that you have done very successfully with the Nebraska Farm Bureau is you have thought outside of the box. You have created a new program that is working in your State. Do you have some examples, without naming names, of course, but maybe give some examples of folks who have enrolled in your plan that maybe weren't able to get on the ACA, who are now getting healthcare coverage? Do you have some personal examples of this?

Mr. Robertson. Yeah, sure do. We have a member of our board of directors that did not participate in the ACA last year and signed up for association plan this year and saved $7,000, $8,000, and so that is a question -- they had an alternative plan, but it wasn't near ACA-compliant and didn't cover preexisting conditions. But now they are covering all of those conditions at a lower cost than what it would have been on the individual market with ACA.

So, in my mind, that is win. Not a week didn't go by without -- or a day go by during signup where we heard stories of our members saving thousands of dollars by joining our association health plan.

Mr. Nunes. And, roughly, how many folks do you have in your plan now?

Mr. Robertson. Nearly 700 members.

Mr. Nunes. Nearly 700. And they have to be Farm Bureau members.

Mr. Robertson. They have to be Farm Bureau members by July 1 of that preceding year because we wanted a 6-month waiting period because we didn't want the next hundred Farm Bureau members to need knee replacements. You know, so that was important.

Mr. Nunes. Uh-huh. And what is the average age? You mentioned the average age in your testimony, but could you repeat that again. The average age of the folks that are in your plan?

Mr. Robertson. We were seeking that information out from our insurance partner yesterday. I think because of some HIPAA laws, we don't have that, but we are guessing it is in the lows 50s. Typically the younger producers might have been eligible for more subsidies on ACA, and so they took the subsidy ACA route rather than our association health plan route. So we think it is a little bit weighted toward the older end.

Mr. Nunes. Do you have an average price for the plan, and can you walk us through the different types of plans that you are offering?

Mr. Robertson. Yeah. Prices vary for age and geography. And we had six products that were offered underneath the plan that we sponsored. And the average prices are anywhere from, we think, $18,000 to $25,000 a year, but again, that sounds like a lot, but when you are paying $36,000 a year, that is a savings. That is realtime savings.

Mr. Nunes. Well, congratulations on thinking outside of the box and coming up with plans, and I think we can learn a lot from your work, and I appreciate you being here today.

Mr. Robertson. Thank you.

Mr. Nunes. Thank you, Mr. Chairman.

Chairman Neal. I thank the gentleman. The gentleman from Texas, Mr. Doggett, is recognized for 5 minutes.

Mr. Doggett. Thank you. How appropriate and important it is that we are focusing on healthcare and preexisting condition as the first formal hearing of this new and much-improved Congress. In understanding where we go forward, it is important to understand the path that has led us to today. And that path is 8 years of Republican persistence in trying to destroy the Affordable Care Act and its protection for preexisting conditions. Trying again and again and again, dozens and dozens of times, to repeal the Affordable Care Act and its protection for preexisting conditions, and failing on those efforts. Then moving to try to weaken and undermine the Affordable Care Act in any way that they possibly could.

One thing that has been missing from that path is the replace part of repeal and replace. Not once was any comprehensive alternative to the Affordable Care Act and its protection for preexisting conditions ever presented for a vote in this committee or any other one. It is great to hear that they want to work with us, and I hope that they do, in moving to a better place and correcting some of the obvious deficiencies of the Affordable Care Act. But it would be even better had they advanced a comprehensive replacement, if they had one, for a vote and action over the course of the last 8 years.

On Inauguration Day, not even getting to the inaugural dances, President Trump decided to join their effort to destroy the Affordable Care Act, and he issued an executive order on that day to tell all Federal agencies to do everything they could to undermine the Affordable Care Act. And the most recent example of that is what is clearly collusion. It is collusion between an indicted Texas attorney general who sought to destroy protection in the court with preexisting condition and the Trump administration, which, instead of

defending that protection for Affordable Care Act, decided they would just lay down and play dead. And had it not been for the important intervention of attorneys generals from States across the country to defend the Affordable Care Act, there would have been no contest over this total capitulation by the administration.

Republicans can tell us that they believe in preexisting conditions, but this is more than passing some sense of Congress resolution, it is a matter of structuring a way of accessing healthcare that does protect without exorbitant premiums those many Americans, almost half of Texans, who have preexisting conditions.

Perhaps the most troubling aspect, in fact, of preexisting conditions, maybe the most overriding preexisting in America today, is amnesia, the political amnesia of those who have forgotten what it was like before the Affordable Care Act and how it was that those who would get a diagnosis of a serious disease would also be getting an effective diagnosis of financial ruin if there was no protection for them before the Affordable Care Act.

The Affordable Care Act is far from perfect. One of the areas that I hope our committee will focus on is how we get an answer on the question of prescription price gouging, the need for Medicare and negotiation, the need for more competition to reduce those costs.

But, Ms. Brooks-Coley, I would ask you one question. Across my area, I have been to so many Relay for Life events where cancer survivors come out and people from the community come out to support the American Cancer Society, and one of the statistics that I remember from those gatherings is the indication that if you don't have insurance -- and of course, in a State like mine in Texas with an indicted attorney general who keeps fighting Medicaid expansion, we have more uninsured than just about any place in the country, probably just about any place in the industrialized world -- that you have a

60-percent greater chance of dying with cancer if you lack insurance than if you have access, such as through the Affordable Care Act. Is that still the case?

RPTR MOLNAR

EDTR HUMKE

[11:00 a.m.]

Ms. Brooks-Coley. Thank you for the question, Congressman. That actually is a 2017 statistic from our Cancer Journal, and it is a really important statistic that we actually cite oftentimes when we are having conversations about why patients with preexisting conditions have access to coverage.

American Cancer Society research has shown that access to coverage and your ability to have health insurance is a deciding factor, if you have a serious illness like cancer, what your diagnosis stage would be, as far as when your cancer is found, what your treatment outcomes will be, how quality those treatment options will be, as well as survival rates. And speaking to your direct question, survival rates are directly linked to an individual's ability to have access to affordable, quality, and comprehensive healthcare.

Mr. Doggett. Thank you.

Chairman Neal. I thank the gentleman. I thank the gentleman. With that, I would like to recognize the gentleman from Florida, Mr. Buchanan, for five minutes of inquiry.

Mr. Buchanan. Thank you, Mr. Chairman, for this hearing. I also want to thank all of our witnesses.

First, I want to say myself, and I know Republicans support preexisting conditions, but I wanted to mention something else. Being someone that has been in business for 30 years, this is always my favorite time of the year, the beginning of the year. We got a new Congress. We got -- a lot of us are new on this committee. I would challenge all of us to find a way that we can work together. These are big issues.

My big, most passionate thing I am passionate about is the rising cost of healthcare.

I read in the paper, USA Today -- and I have thrown this out before, but a year ago, it struck me so much -- that 62 percent of Americans don't have a thousand dollars in the bank. They are living paycheck to paycheck. And when I thought about that, for someone that has been in business 40 years, many years before I got here, we paid for everybody's healthcare for 20 years.

And then the next 20 years, the costs continue to go up, not just in terms of ObamaCare, but in terms of the costs going up. We have got to find a way to bend the curve on costs because it is bankrupting, in my mind, the middle class, and we talk a lot about the middle class.

I would just tell you I met, you know, met a lot of people, over in Florida, anyway, about healthcare costs. One gentleman said to me that he is paying -- the company is paying 700, he is paying $700 a month out of his pocket for a family of five, a young family, and then he has an $8,000 deductible. So as they have had children, it cost $8,000 a year, that is having to come completely out of pocket.

Another gentleman, Roberto, has an Italian restaurant, that he has had, and he was telling me that his healthcare cost is something you mentioned, $3,000 a month. So it is clearly affecting everybody.

And my point is that cost is getting pushed to the middle class. That is why they don't have any money, you know, at the end of every week, or at the end of every month, because they are having to pay more themselves from that standpoint.

I think there has been probably some good ideas in terms of Oregon and Massachusetts. We should look for the best practices, the best ideas, and find a way to bend the cost of healthcare costs. That is what we should be doing, not playing the blame game. We are here today, let's find a way with a new Congress, how we can move forward and start having an impact.

I think the spending last year or this year is $3.5 trillion that we spent on healthcare. There has got to be ways we can find more efficiencies by working together. So my focus is on how do we bring the costs down.

Ms. Pollitz, let me ask you, what is your suggestion for this committee in terms of how we can work on a bipartisan basis to start lowering the costs? What would be some of the things that you might suggest?

Ms. Pollitz. Well, Mr. Buchanan, I work for the Kaiser Family Foundation, and we actually don't make policy recommendations, but we do provide information. We have a lot of information on our website and on our partner website, the Kaiser-Peterson Health Tracking site that provides a lot of data on healthcare costs and where they are rising and why they are rising. And I think we would be very happy to sit down with you or any other Members and kind of review that information for you and suggest other things.

Mr. Buchanan. My thought is, how do we start vetting the curve on the costs?

Mr. Robertson, you mentioned -- and I chaired our chamber in our area, in Sarasota, Florida, there is 2,400 members in there. 80 percent of the members are 15 employees or less, exactly what you are talking about. It looks like you have got about a 25 percent, 30 percent savings, through this association concept, which we weren't able to put in place in our chamber. We tried, but for whatever reasons, outside groups had more influence, but is it your sense you are going to be able, hold on to the savings that you have got so far?

Mr. Robertson. Yeah, we really do. I mean, it all depends on how the history looks of the whole group, of the association health plan in the first year out. We don't have experience on this group yet, but we sense we will. And as the group gets larger, which we are getting a lot of interest -- more members signing up this year -- as the group

gets larger, just because of the fact it is larger, you can spread more of the risks and the costs out with the whole group. And so we hope that that 25 percent becomes 30 percent, 35 percent reduction from the --

Mr. Buchanan. You mentioned that they all have preexisting condition coverage, right, as a part of that package? So you didn't drop any of that out to get to the savings?

Mr. Robertson. No, no, the savings is just related to how large groups are rated, basically.

Mr. Buchanan. Thank you, and I yield back.

Chairman Neal. I thank the gentleman.

With that, let me recognize the gentleman from California, Mr. Thompson, to inquire for 5 minutes.

Mr. Thompson. Thank you, Mr. Chairman, and thank you to all the witnesses who took time to be here today for this very important hearing.

I voted for the Affordable Care Act, a bill that was not written in the back room, a bill that was written in full public with hearings, amendments, hearing from witnesses, and I did that because I believe every American should have access to quality, affordable healthcare, including Americans with preexisting conditions. And it has worked.

In my district alone, the uninsured rate dropped from a full 10 percent, from 15.9 percent in 2013, to 5.9 percent in 2017. And that is, in large part, because folks with preexisting conditions had access to a healthcare market that they didn't before.

And you heard from my constituent, Mr. Blackshear; he was one of those people who gave an outstanding explanation of his personal situation. Every one of us have heard from constituents in our district. Every one of us can talk about an example to this. The last time we met, I shared with this committee the fact that my sister-in-law who is a dental hygienist, married to a young minister, couldn't afford healthcare in their State of

Florida. Both starting out in their business, and it wasn't until the ACA was passed did she have access to healthcare. And it was shortly after that, that she was diagnosed with a very serious cancer. She has undergone some pretty extreme procedures for that. She is home. She is doing well.

And the number one concern that she has is, now that she has a preexisting condition, will she be able to continue to have healthcare. She is scared to death that somehow she is going to lose that if the ACA goes away. And that is not what we should be doing. We should make sure that this is, in fact, the law of the land, because it is the ACA that made that possible.

And, Mr. Robertson, I want to thank you for your testimony and particularly the point that you made on a couple of occasions, and that is that your Farm Bureau policy is ACA-compliant. That is an important factor. Because if it weren't for that, it could very easily be another junk policy, that takes your members' premiums, and they are there for you every step of the way, unless you become injured or you become ill. So it was the ACA that provided that protection.

Mr. Blackshear, you purchased your short-term healthcare policy a few months before you fell ill. The following November you said that when open enrollment hit, you purchased a plan through Covered California, our marketplace for the ACA. Can you describe how the patient experience changed on a day-to-day basis after you purchased a plan through Covered California?

Mr. Blackshear. Yes. Basically, just the anxiety, that was the huge thing. Being sick, you know, and especially severely, in heart failure, seeing bills that aren't being paid, and I am having to run errands. It was pretty difficult. So I would say the biggest thing is just the anxiety surrounding it, you know, that, wondering, I am paying my premiums, but are they going to help me out, you know.

Mr. Thompson. And we have heard a lot from the dais today from our colleagues on the other side who keep raising the issue of the cost of healthcare through the Affordable Care Act. Talk a little bit about what you pay and the difference between what you pay for your ACA policy and your short-term policy that didn't provide you the care that you needed.

Mr. Blackshear. With no income change, my short-term plan was $160 to $180 premium per month. And then surprisingly, when I got on the ACA, it went down to $70 a month.

Mr. Thompson. This was after you were diagnosed with a very serious healthcare issue?

Mr. Blackshear. Yes, yes.

Mr. Thompson. Thank you very much.

Mr. Stolfi, you talked about your Oregon plans. In California, California recently passed legislation prohibiting these short-term, junk plans. Has Oregon done something similar?

Mr. Stolfi. Thank you, Representative, for the question. We -- in 2017, our legislature passed a law limiting short-term plans to what was then the federal requirement of 3 months. It was a policy decision made at the time, and we are very happy with that decision.

Mr. Thompson. And all the plans that you sell are compliant with the ACA?

Not you sell, but the State -- sold in the State?

Mr. Stolfi. Well, the short-term plans are not required to be compliant, which is the problem with them.

Mr. Thompson. Thank you very much. I yield back.

Chairman Neal. I thank the gentleman.

With that, let me recognize the gentleman from Nebraska, Mr. Smith, for 5 minutes.

Mr. Smith of Nebraska. Thank you, Mr. Chairman. I appreciate the opportunity to have this hearing and bring some attention to the fact that there is a lot of common agreement in terms of preexisting conditions. Actually, what we as Republicans have proposed previously and actually voted on, and I do want the record to reflect that we did vote on an alternative that would have, I think, proven very effective to consumers to be able to have options and actually to afford health insurance.

It concerns me greatly when we see an increase in premiums to levels that are -- I never even thought imaginable before we even had that vote back in 2009 and 2010.

And so, as we process this -- and Mr. Buchanan certainly pointed out how important it is that we work together to find a way forward so that the American people will not be harmed, because let me be very clear, many Nebraskans have been harmed by the heavy hand of the Federal Government saying that they have been helping them, and that the government has helped in ways that many Nebraskans would tell me they have actually been harmed. So I do have some questions.

Ms. Brooks-Coley, you referenced exorbitant premiums that were paid before the ACA came about. What would you list as an example of an exorbitant premium?

Ms. Brooks-Coley. From the cancer perspective, one of the concerns that our patients had before the ACA, and before the important patient protections included in the law, was the fact that our patients had to oftentimes pay more for their care. Sometimes they had insurance plans that did not actually cover cancer treatment and had to pay exorbitant prices to actually access lifesaving chemotherapy, radiation, other treatments.

So those exorbitant prices, that even if they had coverage, may not have actually covered the actual care that they needed, was extremely harmful.

If you look now at the Affordable Care Act and the patient protections and the essential health benefit requirements that is in the law, our patients don't have to worry about those costs, and they are paying their premiums and paying for the expenses that they have with the understanding, though, that they won't be hit with exorbitant costs that could impact them and their family members.

Mr. Smith of Nebraska. So a high-risk pool, you are telling me, would pay a higher premium before the ACA. Is that correct?

Ms. Brooks-Coley. I am sorry, Congressman.

Mr. Smith of Nebraska. A high-risk pool that would have covered preexisting conditions, even before the ACA, that those premiums would have been higher than others, are you saying?

Ms. Brooks-Coley. I was speaking specifically to the fact that there may have been services they had to pay for out of pocket that weren't covered by those plans.

Mr. Smith of Nebraska. Okay, all right. And thank you.

I am concerned that some of the high-risk pool premiums that that were around prior were higher, but now we see more people paying similar premiums, as Mr. Robertson pointed out. Even the 19,000 roughly premium per year, that is still a lot.

Ms. Brooks-Coley. Right.

Mr. Smith of Nebraska. And so that is why I hope we can work together on a way forward to bring that down. Because even if there are preexisting conditions that are covered in a mandatory fashion, if the premium is out of reach for a rate-payer and they can't afford it, there is not a lot to do about that. And it is certainly unfortunate because it ultimately reduces access. I mean, we see that even folks in California who qualify for an ACA plan, only 40 percent opt for that plan. And I think we need to get to the bottom of why and how that has come to be the situation.

I think of Pam in my district, who liked her plan before all of this came about. She had a plan that she liked. It covered her preexisting condition. She was canceled and that is unfortunate. She lost coverage through no fault of her own four times because the government said they were trying to help her, and that should be unacceptable to us as policymakers.

And certainly we want the American people to have more choices for coverage. And I am glad that the Nebraska Farm Bureau has at least given another choice to its members because we have seen choices diminish, certainly in Nebraska, since the ACA came about.

Thank you, I yield back.

Chairman Neal. I thank the gentleman.

With that, let me recognize the gentleman from Connecticut to inquire for 5 minutes, Mr. Larson.

Mr. Larson. I thank you, Mr. Chairman, and I thank you most of all for something that Mr. Buchanan said -- this is the start of a new Congress and a commitment to have public hearings and to have them often and to go to regular order. And I would point out to my colleagues on the other side, and I often wonder when they say "ObamaCare" if they mean it in the same way that we do in terms of Obama truly caring about the people of this country. I will give them a pass and say that is what I think they mean on this and not the derisive nature that oftentimes -- that it takes.

What we are going to need here on this committee is the kind of format that Mr. Neal has indicated this committee is going to be dedicated to, and that is to have public hearings as we did during the Affordable Care Act, and make sure that everybody has an opportunity to go back and forth.

Our colleagues on the other side, it doesn't seem that there is much disagreement

with us between preexisting conditions. We should, therefore, all be able to reach the -- a conclusion rather quickly.

I want to ask the panelists real quickly. All of you as you have sat here today, you all agree that there should be no limit, that anyone who has a preexisting condition ought to be able to get an insurance policy, correct? Is there anyone who would disagree?

Anyone disagree, of our panelists, what Mr. Lewis had to say, that because of the nature of health insurance -- Mr. Robertson, you have seen it up front with farmers. All of you have experienced it in one form or another. Should it be a right? Can I see a show of hands? Should it be a right, yes? You all believe that it should be a right, as Mr. Lewis has pointed out.

What we have here is an infrastructure problem, and what we find in Congress when we have an infrastructure problem, even though currently our national infrastructure, Mr. Blumenauer would tell you, has a D-minus rating by engineers, et cetera; I would say our overall health infrastructure -- and by that, I mean our own personal health and well-being -- is an infrastructure problem.

And in both cases, what Congress has to do is come together and talk about what is necessary to improve that infrastructure. And it is not roads and bridges in this case, but it is arteries and disease and preexisting conditions. But like all of these, they come at a cost. And so while Congress may strongly agree about the need, when it comes to paying for it, that is where the disagreements come in. And that is the bottom line here.

Mr. Robertson, you have talked about pooling resources and everybody coming together. What a great thing. A colleague of ours here, Brian Higgins, has come up with an idea, and I want to quickly ask you this. What about if we were to have 50-year-olds be able to buy into a Medicare system? A Medicare system that the Kaiser Family Foundation said that if a 60-year-old bought into the plan, it would be 40 percent less than

the Kaiser Family Foundation -- excuse me -- than the Affordable Care Act gold plan. Is that something you could agree with?

Mr. Robertson. Well, it depends. I mean, there is a lot of value to pool individuals together.

Mr. Larson. Precisely. And --

Mr. Robertson. But if you don't address the cost side of that equation --

Mr. Larson. Sure. But let's say if it was age 50 years old, again, and you could buy into a program which would make it revenue neutral but would look at the older end of the people that you cover from, say, 50 to 64, they would get a break, and the Medicare group would be much younger as well. Also, the younger group would become 27 to 49, driving, as you know, insurance down dramatically.

Mr. Robertson. Right. Again, there is value with pooling resources, but until you address the other side of the equation on cost of providing healthcare, somebody has got to pay for those plans.

Mr. Larson. Exactly. And so what would you suggest?

Mr. Robertson. There is a lot of things that I think are not looked at yet by Congress and policymakers, but there is some -- I think, some market innovation programs that can be looked at to make a health insurance system work.

Mr. Larson. We are running out of time, but if you would submit those to us we would be happy to take a look at them.

But thank you for your testimony. I want to thank all the panelists. I yield back.

Chairman Neal. I thank the gentleman, and let me recognize the gentleman from Texas, Mr. Marchant, to inquire for 5 minutes.

Mr. Marchant. Thank you, Chairman Neal. Congratulations on your chairmanship. I am looking forward to working with you and with our leader, Mr. Brady,

on finding some solutions that will positively affect my constituency. I want to echo Mr. Brady's statements and make sure that my constituents back home know that I support protecting access for all patients with preexisting conditions.

We all agree that protecting these individuals is necessary, and I will look forward to working on policy solutions that address the uncertainty that surrounds these individuals. Sadly, current law is riddled with problems that make it a litigator's dream and a patient's nightmare.

So I will ask the panel -- and I have heard each of your stories and what you do. I would like to ask you a very specific question, though, and if it doesn't apply to you, just say, it doesn't apply to me and I don't have an answer for you. But what law or laws would you propose Congress pass that the President could sign, that would give individuals with preexisting conditions the certainty that they need when it comes to utilize their coverage?

Ms. Pollitz?

Ms. Pollitz. I am sorry? The certainty to utilize their coverage?

Mr. Marchant. Yep.

Ms. Pollitz. I am not sure what you mean by that.

Mr. Marchant. Make a claim, have it paid.

Ms. Pollitz. Getting the claim paid?

Mr. Marchant. Yes, ma'am.

Ms. Pollitz. I mean, the ACA does require that people have access to insurance regardless of their preexisting conditions. It does require that insurance provide essential benefits, at least in the individual and small group market, and it provides subsidies to make all of that work.

Mr. Marchant. So you would propose no new law to change what is on the books

now?

Ms. Pollitz. I wouldn't propose laws one way or the other. I am just saying there is that law. As I think the members have discussed today, not everybody gets coverage under the ACA. Particularly it is difficult for people who don't qualify for subsidies.

There are other limits. We haven't talked too much today, for example, about -- well, actually, I think, Mr. Brady brought up network adequacy, and whether the plans that are there for people then cover a sufficient number and distribution of doctors and hospitals. I think it is fair to say implementation of network adequacy standards under the ACA hasn't gotten very far. The Obama administration, toward the end, began to ask --

Mr. Marchant. But my question was about preexisting --

Ms. Pollitz. But now the Trump Administration isn't even looking at that anymore.

Mr. Marchant. My question is about preexisting conditions. This is the purpose of the hearing.

Mr. Stolfi?

Mr. Stolfi. Thank you, Representative. I would say that a prior Congress has already passed, and the President has already signed, a piece of legislation that protects people with preexisting conditions, the Affordable Care Act. And as far as helping those individuals further when it comes to the costs that they are faced, and all individuals, actually, with coverage work can be done on, as one of the panelists has mentioned, the cliff.

So individuals at and over 400 percent of poverty level, helping those individuals get more subsidies to help. Cost-sharing reductions could be funded so that we could see rates come back down --

Mr. Marchant. That would be addressing preexisting conditions?

Mr. Stolfi. People with preexisting conditions and people without. So every person with insurance would benefit.

Mr. Marchant. Okay, thank you.

Mr. Robertson?

Mr. Robertson. Well, I am here talking about the association health plans, and I think more laws and regulations to improve and reform association health plans would be very helpful to help cover preexisting conditions.

Mr. Marchant. Ms. Brooks-Coley?

Ms. Brooks-Coley. Thank you, Congressman. The American Cancer Society Cancer Action Network supported the Affordable Care Act for that very reason, because of the patient protections that are included in the law, that made sure that patients who had serious illnesses such as cancer, and had preexisting conditions, had access to the coverage that they need.

Mr. Marchant. Thank you.

Mr. Blackshear?

Mr. Blackshear. With a policy question like this, I would refer you to speak with the people that I work with in the AHA.

Mr. Marchant. Okay. Thank you.

One of the real-life situations that some parents in my district face are children that are privately covered on their parents' insurance plans now,

but their disabilities and their sickness will go much past the 27-year-old limit. And they fear that eventually, when they pass away or their coverage goes away, there is a retirement, that when they have to switch that child to Medicaid, that the preexisting

condition or the level of care will not be adequate or compare to the level of care that they are getting on the private insurance. Anyone have a comment about that?

Chairman Neal. The gentleman's time has expired.

Mr. Marchant. Thank you.

Chairman Neal. Let me recognize the gentleman from Oregon, Mr. Blumenauer, to inquire for 5 minutes.

Mr. Blumenauer. Thank you, Mr. Chairman. I appreciate our having this discussion today and I think it is appropriate to start out. Although I must confess that I would think my good friend from Texas, the ranking member, would be embarrassed to critique the Affordable Care Act process, the dozens of hearings, the work that went on, to the -- I don't even know how to describe jamming through the largest transfer of wealth in American history without a hearing, with people not knowing what was in it to this day.

When the history is written of what happened in the -- in this last decade, that claim will be laughable. And I hope we can get past it.

Mr. Chairman, one of the things I think is important, two of the witnesses, Ms. Pollitz and Mr. Stolfi, pointed out that we have legislation now that reaches the requirement for preexisting conditions. The only problem in terms of gaps is that not adequate funding for subsidies and chipping away at some of the things that are going on. We have got it now.

Now, notwithstanding legislation that my Republican friends passed to try and give themselves a fig leaf before the last election, what they did is not sufficient, is not as good as the Affordable Care Act. They can say that they want to do that, but it didn't speak to the interaction of all of the pieces. That is why they never passed legislation and enacted into law to replace the Affordable Care Act. They couldn't do it and meet those standards.

Or as the President of the United States said, healthcare is complicated. Who

knew. Who knew. But the fact is, what you came up with is not as good as what we had, and if we would have been working together, for the last 6 years, to refine and enhance the Affordable Care Act, coverage would be better, costs would be lower, and we could move on to other areas that we agree need help.

Now, Mr. Stolfi, you have, in your testimony, impacts of what happened with Republican Congress and the administration that have driven up costs, not reduced them but driven them up. Do you want to point to your testimony? I think people missed that, that the things that the Republicans have done and the administration is pursuing, according to your testimony, it has harmed people in my State.

Mr. Stolfi. Thank you, Representative, for the question. Yes. So we are calling it federal uncertainty, but it is a contribution of a number of factors. It is the short-term limited duration plan changes, association health plan changes, zeroing out of the federal mandate, the Texas lawsuit, the loss in marketing dollars to promote open enrollment at the exchanges. All of these things have a real-life impact on people.

In Oregon, they have influenced the rates that people are paying in 2019, by increasing those rates between 7 and 14 percent over what they otherwise could have been, without this unavoidable Federal uncertainty.

Mr. Blumenauer. Thank you. The witnesses have pointed out, there has been some problems earlier. Getting a massive proposal in place, insurers made bids that weren't accurate, and it took them a couple years to be able to get it right. That is not something that should be surprising for something that is dealing with this much of the economy. It will take time to get it right.

But what has happened, is that while they are working to get it right, my Republican friends and the administration have created greater uncertainty, getting rid of the mandate, having problems in terms of cost-sharing reductions. Things that were

envisioned in the bill that were part of making it work properly, unnecessarily put this uncertainty in a business that doesn't thrive on uncertainty. They are risk adverse. They want good information.

Mr. Chairman, I appreciate our having a discussion like this today. I think as we go through, I think we will find areas that we don't need to make it worse. We ought to take a bill that, as enacted, it is providing what people want for preexisting conditions, not chip away on it, but refine it.

Thank you, Mr. Chairman.

Chairman Neal. I thank the gentleman for his inquiry. And now let me recognize the gentleman from New York, Mr. Reed, for 5 minutes.

Mr. Reed not being here, let me recognize Mr. Kelly for 5 minutes.

Mr. Kelly. Thank you, Chairman, and thanks for having this hearing. And to all the witnesses, thanks for taking time out of your private lives to come here.

This hearing today was about preexisting conditions and what is covered and what is not covered. But most importantly while it is called the Patient Protection Affordable Care Act, the most obvious part of it is the "Affordable" Care Act.

I don't know how many Members sitting up at the dais today actually buy health insurance. I am still in the private sector and we do provide employer-sponsored healthcare and pensions, by the way. I think one of the biggest challenges is that how do you afford to do that, especially if you are a small employer. And I think that is where we come in with the association health plans.

And I think, Mr. Robertson, that is the key to how even small employers can offer a benefit to their associates that lets them compete in an open market for talent, part of that being benefit programs.

In Pennsylvania, by the way, there is a company in Fairview, Pennsylvania, which

is just outside Erie, and I represent them -- there is new ownership, 13 employees. The owner wants to provide health insurance for his employees, but can't afford the rates for them.

Now he wants to join an AHP through his business association with the manufactured business association in Erie, but the Governor of Pennsylvania says “no, no, you can't join an AHP; Pennsylvania isn't providing that.” And I got to tell you, we hear all this back-and-forth about what we do. We have always supported preexisting conditions. It is just flat out what we do because we believe that.

Being an employer, I believe that because of the people that I work with every day for mutual success. And to try and divide some -- or develop some type of a plan that says, “no, they don't want this,” that is not true. I think what all of us want is something that is truly affordable.

Ms. Brooks-Coley, you know I am a Hyundai dealer. Hyundai Motor America, Hyundai dealers have something called the Hyundai Hope on Wheels. We just finished our 20th anniversary, and through Hyundai dealers and Hyundai Motor America, have contributed $125 million to the research for pediatric cancer. So there is nobody in America that says, “nah, they don't deserve it”;” nah, we can't go down”; “too expensive.” "Too expensive" is true because sometimes your heart is willing but your wallet is weak; you don't have the resources to do it.

But, Mr. Robertson, I want to get to you because there is an answer to people who want to provide healthcare. And they want to provide it for their associates. But if you are eliminated from doing that -- and I think you covered it very clearly. One of the ways we develop healthcare programs is through what, age and geography, which is a little bit different than the way I would think about it. But I would think risk is probably something that should be figured in there, too.

And I am not saying people with preexisting conditions shouldn't be covered, but it has to be factored in.

Tell me, how else would a small employer be able to get the same benefits as a large group for the rates that they need to have, in order to remain competitive, and in their line of business or their competition, to find talent out there, and wanting to take care of those people?

Mr. Robertson. Well, I think it is problematic for individuals or small employers. Again, it is all economics. Size matters. If you can pool a larger group, you can address the preexisting conditions, but because you are in a larger group, you can spread out the risk. And so if you are a small employer, a farmer/rancher, and if you are only yourself, that is hard to deal with the risk.

But we can address preexisting conditions if you are allowed the individual and small markets to pool together all their resources and risk. That is the way to do it. It is pretty simple.

Mr. Kelly. It is pretty simple, and the reason that it can be affordable is because you widen the universe of who is paying premiums.

Mr. Robertson. Correct. I mean, large employers do it today. It is pretty simple. You widen the pool and you can lower administrative costs. You can lower other associated fees with that large group. Right now, we are trying to force the small and individual group to cover preexisting conditions. That is why the costs have gone up on the premiums, to where they are 30- to $36,000 a year for farmers and ranchers of Nebraska. We got to pool them up and --

Mr. Kelly. Let me ask you this, because we are all agreeing on the same thing. Right? We want preexisting conditions covered. We want to make sure that employers can offer this.

Why would they want to exclude the association health plans? For what reason? What would be the purpose of doing it? Because basically with the Affordable Care Act, they wanted more people paying in that were actually filing claims. So it is the same principle. Why are AHPs under fire right now, with no, you are not allowed to have those? For what reason?

Mr. Robertson. I don't know. I think that is the best reason to move forward, to cover preexisting conditions because you are using market forces with insurance companies to spread those risks to cover preexisting conditions. That is what needs to happen.

Mr. Kelly. And I want to encourage you to keep going. I know the farmers in Nebraska appreciate what you are doing. I got to tell you, Manufacturers Associates in Erie, over a thousand members in that plan. What a shame to be able to tell those people now, you can't participate on a level you can afford; we are going to force you into some other market. That is not what America is; that is not what we have ever been. We are about innovation. So I thank you for your time here.

Chairman, thank you, and I yield back.

Chairman Neal. Thank you, Mr. Kelly, and with that, let me recognize the gentleman from Wisconsin, Mr. Kind, to inquire for 5 minutes.

Mr. Kind. I thank you, Mr. Chairman. I want to thank you for holding such an important hearing for our initial kickoff as a committee, and I want to thank the witnesses for your testimony. And I am so happy to hear such wide, bipartisan support for the need to protect individuals with preexisting conditions. It is just fundamental in our healthcare system. I am glad to see that consensus developing.

Mr. Robertson, let me ask you, and listen, I am an owner of a family farm myself in a large, rural, Western Wisconsin district. We rotate corn and beans, have some beef

cattle, and so I am operating in farm circles quite a bit. And I am glad to hear that you are coming up with a solution in Nebraska with these AHPs that are addressing one of the shortfalls, quite frankly, that existed under the Affordable Care Act. That is those individuals trapped in the individual marketplace that are not qualifying for a premium tax credits to lower their healthcare costs. You are trying to address it right now with the AHPs.

Clearly it is not something that is prohibited under the ACA, because the Nebraska AHP is ACA-compliant, which is all that we have been asking. The concern with the AHPs, though, is if it wasn't ACA-compliant, they would be offering junk plans that wouldn't cover very much and, therefore, offering them cheaper, and it would strip a lot of the younger, healthier people and gravitate to those plans as to the more comprehensive coverage that virtually all of us ultimately need at some point in our life.

But let me ask you a couple of questions, because I am dealing with the same issue in Wisconsin. The average farmer's age in Wisconsin, 60, 61, like you said it was in Nebraska. Are you worried with the health pool that you have established with the AHP, with the average age about 60 and the fact that as we grow older, we consume more healthcare, healthcare gets more expensive, and what that is going to do with your premiums in the future, with that aging population within your health plan?

Mr. Robertson. No, no, we are not. I mean, we built this plan to last for a long time, the next 5 or 10 years. And so we build it to be ACA-compliant, and we think as we grow the pool, we hope this thing becomes not just 700 members, but it becomes 3-, 4-, 5,000 Farm Bureau members.

Mr. Kind. Are you also worried about maybe the extraordinary event that might happen with some of your members, whether it is cancer, with the extraordinary costs that might come with one or two individuals contracting cancer and having to deal with those

expenses, what that might do with the AHP premiums in the future?

Mr. Robertson. Yeah, I mean, that is always a concern because you have to have an association health plan that remains solvent. And so there is that concern out there. But, again, the track records will show, with all these large employers, the larger the group, the more you can address those type of large events.

Mr. Kind. And I think there is great agreement on that point. It was just interesting, because I did encounter this article of the World-Herald Bureau, written by Joseph Martin, talking about Nebraska AHP plan.

And, Mr. Chairman, I would ask unanimous consent to get the article included in the record at this time.

[The information follows:]

Mr. Kind. But in it, Mr. Jeff Bartsch who is Medica's vice president, who is offering the health plan for you, was asked how the initial premiums were established, and he was quoted as saying, we had an opportunity to just assess who the potential association members would be, and their health risk is lower than the remaining individual market, and that is why you are seeing some better premiums being offered.

But he also pointed out there are over 90,000 people in health insurance exchanges under the ACA in Nebraska who are still in that pool, and the vast majority of them are receiving premium tax credits to lower their costs.

I know in Wisconsin -- I don't know what it is in Nebraska -- but 87 percent of the participants in the ACA health insurance exchange in Wisconsin are qualifying for these premium tax credits, substantially reducing their costs, and that is why so many have signed up for it.

But Mr. Bartsch also went on to say that the association, in our mind, is really targeting, again, either people who have left the market already, or those people who are still in the market but don't receive a premium tax credit. So that is the issue, really, the roughly 5, 6 percent of the overall population of the country. Mr. Bartsch, that is just a small overall portion of the overall population that fits that definition.

And that is one that I hope that we could find some bipartisan agreement. How do we address that small portion of the American population stuck in the individual marketplace, not qualifying for premium tax credits?

I know Mr. Neal and others of us have offered legislation to address that by expanding these premium tax credits to cover more individuals. That is another way of addressing it.

But I am just concerned that with demographics, with an aging population, extraordinary health events, such a small pool of 700 members -- you are hoping to grow

that -- what that might do to future premiums.

Let me finally ask you, most of your members when they hit 65 then transfer into Medicare?

Mr. Robertson. Yeah. Yeah, they do.

Mr. Kind. And Medicare is a great program, and they have to take all newcomers, whether you have a preexisting condition or not. Medicare is able to spread that risk out.

Do you have a prediction that if there was an early buy-in option to Medicare, that is budget neutral, that some of your members might find that an attractive option?

Mr. Robertson. I do not. No, I am just here on the association health plans. I appreciate that --

Mr. Kind. Fair enough. Fair enough.

Mr. Robertson. But on your point, on the Federal poverty level, we even saw those members who are in the 250 to 400 percent Federal poverty level -- actually, our Farm Bureau plan competed with that tax credit, and we were able to pull some of those away from that tax subsidy -- or that premium subsidy. So that was good news we saw.

Mr. Kind. That is good. We will watch it very closely. Thank you. Thank you all.

Chairman Neal. I thank the gentleman, and with that I would like to recognize the gentleman from Missouri, Mr. Smith. And after Mr. Smith inquires, we will move to establish precedent on the committee, having two witnesses on our side for one on the other side. With that, Mr. Smith is recognized for 5 minutes.

Mr. Smith of Missouri. Thank you, Chairman. I look forward to working with you and the Republican leader on the important business upcoming in this committee.

We all agree that protecting access to coverage for individuals with preexisting conditions is necessary. I look forward to working with you, Mr. Chairman, on solutions

that offer certainty to our most vulnerable. That being said, the status quo is full of problems that have made many patients' nightmares become reality.

In 29 of the 30 counties I represent, Missourians only have one insurance provider on healthcare exchanges. Lack of choice has skyrocketed costs.

You know what fails to protect patients with preexisting conditions? Deductibles so high that you might technically have insurance, but it is effectively meaningless.

Lack of choice. A noncompetitive marketplace full of options that don't meet your needs.

What will fail to protect patients with preexisting conditions? Failing to address Medicare solvency before it becomes insolvent in 7 years.

We have to address costs and increase choices in our healthcare system to create a competitive marketplace, so consumers can buy insurance that works for them and meets their needs.

I want to share a letter I received from Marian and Greg from Ozark County, Missouri, in my district: “My husband Greg and I recently moved to Ozark County from Tennessee. Greg had to retire early because of a stroke that he suffered in 2015. We are currently on COBRA and are paying a thousand dollars a month for basically nothing. We discovered that our county in Missouri has only one provider for ObamaCare, and that coverage is even more expensive than our COBRA coverage.

When is Congress going to do something to correct the damage of ObamaCare? Getting rid of the mandate was great, but that is not enough. And why aren't there high-risk pools or some other options for people with preexisting conditions like my husband? We don't want to spend all of our savings on health insurance premiums, especially if we don't receive any benefit. Politicians say that people shouldn't go bankrupt from medical bills. I say that people shouldn't go bankrupt from paying

ridiculously high insurance premiums."

I couldn't agree with Marian more and I hope that the chairman will work with us to find policies to lower costs that we can advance through, not only this committee and the House, but that can pass the Senate and earn the President's signature. I yield back.

Chairman Neal. I thank the gentleman. With that, let me recognize the gentleman from New Jersey for 5 minutes to inquire, Mr. Pascrell.

Mr. Pascrell. Thank you, Mr. Chairman. Doing away with the mandate and cutting subsidies, et cetera, et cetera, is just the beginning of how you try to strangle the Affordable Care Act. Let me -- let me hope you will write some of these things down, because it seems like this is a redo of the last 6 years.

The ACA has substantially improved access to care and financial security. Between 2010 and 2017, the share of nonelderly adults with a problem paying a medical bill fell 21 percent; who didn't fill a prescription, fell 27 percent; who skipped a test or a treatment, fell 28 percent; who didn't visit a provider when they needed care, and that fell 23 percent.

Now, to bolster that, the marketplace consumers are satisfied with their coverage. That has gone from a 36 percent all the way up, now it is 82 percent in 2017. You got to look at these numbers. Instead of doing redos.

Before the ACA, women could be charged more than men just for being born female. Maternity, mental health, and substance abuse were routinely not included in insurance coverage. What are you talking about, you support preconditions? I must have missed a lot of meetings over the last 3 years. And the administration must have missed it all.

Companies could bill consumers for every last dime with virtually no oversight. Someone said before, look at what the conditions were in 2010, which brought about this

situation. If we would have done nothing, if we would have done nothing -- and you are good at doing that -- you criticized us and didn't come up with another plan on preconditions. You got to be kidding me.

The fact of the matter is, you voted more than 70 times to repeal the protections and take us back to the days of uncertain and discriminatory coverage. You did that.

After years of sabotaging the Affordable Care Act, your efforts have served only to make protections afforded to Americans and that law all the more popular today. Thank you.

But the repeated attempts at repealing, gutting, and otherwise sabotaging the ACA, have left us with a lot of work to do to pick up the slack. The committee, in particular, egregiously gutted provisions of the ACA in the 2017 tax bill in December. Remember that? Remember that bill? You didn't even have the guts to run on it. You ran away from the bill. A move that is projected to cost 13 million people to lose insurance. You did it. I didn't do it. No one on this side did it. You did it.

A partisan lawsuit subsequently has tried to dismantle the entire ACA, including its protection for preexisting conditions, and taking away the few assurances we provide Americans in the healthcare marketplace. We must stabilize. No one said that the ACA was perfect. No one said that on this side. In fact, everybody on this side in the last 6 years have offered some kind of situation of amendment to make the ACA better. Because we have never had perfect legislation in this committee or any other committee.

Karen, I just want to ask you one quick question, Karen -- Ms. Pollitz. Republicans have put forward an expansion of a short-term, limited duration plan for -- it is called junk plans -- as a new option to supposedly lower costs for consumers.

Can you describe the pitfalls of high-risk pools, and have they ever worked in the past? And can you describe the problems with these junk plans?

Ms. Pollitz. I will start with high-risk pools if I could.

Mr. Pascrell. Sure.

Ms. Pollitz. I actually -- yes?

Chairman Neal. You will be allowed to finish your answer if you make it succinct.

Ms. Pollitz. Okay. So high-risk pools were a different way of going about this before the ACA in many States, including in Maryland where I live. I was actually on the board of our state high-risk pool. Insurers were allowed to turn people down because of their preexisting conditions and then the State would provide a public program, a high-risk pool that would offer alternative coverage.

That is a very expensive proposition, though. If you only offer coverage for the people who are sick, who account for most of the spending and the risk pool, that will be a very expensive program. States that had these programs, by definition, lost money on every person that they signed up. They were very, very expensive.

So States, over time, started adopting features to limit the cost of programs and to limit the number of people who could enroll. So all but one of the high-risk pools excluded coverage for the preexisting condition, that made you eligible, for 6 to 12 months. They charge premiums higher than standard rates, and even still they lost money on average, about $5,000 a year per person. So it is another way to do it.

There are -- Medicare, for example, covers people with end stage renal disease, so there is a lot of tradition of having a public plan take some of the expensive people and make that sort of the main way of getting coverage. It is just very expensive to do it that way, and without premium financing, there has to be other taxpayer financing to make that work.

In terms of the short-term plans, that is an entirely different approach. That is sort of undoing the risk pool and saying, we can make cheaper coverage available to people

while they are healthy but only while they are healthy. And you heard from Andrew what happens once you get sick in a short-term plan.

So if you believe that you buy insurance in case you get sick, then you want coverage that doesn't stop working once you stop being healthy.

Mr. Pascrell. Thank you. Thank you, Mr. Chairman.

Chairman Neal. I thank the gentleman for his inquiry. With that let me recognize the gentleman from Illinois, Mr. Davis, for 5 minutes to inquire.

Mr. Davis. Thank you, Mr. Chairman, for calling this hearing, and I also want to thank all of our witnesses for coming to share with us.

Much of my focus is on children, because children are such an important part of our population and represent so much of the future. Children living with disabilities such as autism, or ADHD, regularly need therapies or medication to ensure that they can attain and retain their maximum functioning.

Under the ACA, even though children cannot be denied coverage, are charged higher premiums due to a preexisting condition. Sometimes therapies and medications required to address these conditions are not covered by insurance.

Ms. Pollitz, how do we ensure that treatments for children with disabilities are covered by insurance, and how well are we doing with it in the ACA?

Ms. Pollitz. Mr. Davis, the -- let's see. As you pointed out, children with disabilities can't be discriminated against, turned down, charged more, have their pre-ex excluded. The ACA does prior an acute care coverage benefit. So depending on the disability and what it is, there are often limits, I think, to what private insurance would cover, which is why sometimes people end up turning to the Medicaid program which provides a much more comprehensive set of services for long-term services and supports.

And for children, because of the EPSDT benefit, the Early Preventive Screening

Diagnosis Testing -- I forget -- it covers everything that children need, so that is the most comprehensive benefit.

In terms of two of the conditions that you mentioned, autism and ADD -- is that right?

Mr. Davis. Right.

Ms. Pollitz. So that is then -- the ACA is not so specific in that. So there is a standard for essential health benefits that applies in the individual and the small-group market, but those essential health benefits are categories of services. They, by and large, don't include a definition of specific services or specific conditions. States are allowed to then add more detail to the essential health benefits through the benchmark plan that they adopt.

Many States -- I think most States have adopted a standard -- I don't know about Oregon -- to cover services and testing and diagnosis relating to autism, for example.

In other plans, including large employer plans, and particularly self-funded employer plans, at least with these two conditions that you mentioned, there is another law, the Mental Health Parity Act, that does require that plans have to cover services related to mental health conditions at the same level that they do for other medical conditions. I think --

Mr. Davis. Okay. Let me ask you --

Ms. Pollitz. -- insurers can kind of have some discretion, though, about determining what counts as a mental disorder.

Mr. Davis. Good. Parents around the country regularly spend anywhere between $2,000 and $5,000 out of pocket to determine whether their child has a disability because insurance may not cover the tests required to diagnose or assess these conditions.

Is insurance required to cover the treatment associated with preexisting conditions?

Shouldn't it also cover the test or evaluations required to determine whether a child has a particular illness or situation?

Ms. Pollitz. Again, in general, I believe insurance is required to cover diagnostic services, but insurers have discretion to determine what is medically necessary and what falls within the scope of their covered services. I am not sure if maybe in Oregon there is an example of some --

So some States are more specific, particularly with respect to autism and do require private insurance to cover diagnostic services, treatment services. But those State laws would not reach large, self-funded, employer plans, and that may be where your constituents are finding that -- that they are finding gaps in their private coverage.

Mr. Davis. Thank you so much for that kind of clarity.

Thank you, Mr. Chairman. And I yield back.

Chairman Neal. I thank the gentleman. With that, let me recognize the gentleman from South Carolina, Mr. Price, for 5 minutes.

Mr. Rice. That would be Mr. Rice, but you were close.

Chairman Neal. Mr. Rice, I am sorry.

Mr. Rice. No problem, Mr. Chairman.

The theory of the Affordable Care Act was to provide universal coverage for people, including those who had preexisting conditions, and that we could keep the costs down by adding to the risk pool because people were basically not required to buy insurance but penalized if they didn't. And also to bring down the health insurance cost.

As you will recall, the President said, you know, if you like your plan, you can keep it, which is clearly a falsehood. When he said, if you like your doctor, you can keep him, which often proved not to be true. And he said it would bring down the cost of health insurance, which, in fact, the opposite has been painfully true.

Expanding the insured base was one of the goals, and the other goal was to bring the cost down. This first chart here is of the insured base, and it clearly shows that before the Affordable Care Act, 85 percent of America were covered, either by private, employer-held insurance, which is the bottom of each bar there. The first bar is 2010; the last is 2017. But at the bottom in the blue there is employer insurance.

And then the -- I am skipping the middle, the purple part is Medicaid, and then the orange is Medicare, and then the yellow is the uninsured population. So the uninsured population has shrunk some. It was 85 percent, just before the Affordable Care Act hit in 2013; now it is 91 percent.

So we have insured 6 percent more people. That is good. That is a laudable goal. We want to insure as many people as we can. But what is the cost of that? Next chart, please. So to insure those 6 percent more people, we have -- this is insurance premiums. The first bar is 2013; the last is 2017. Average insurance -- individual market insurance premiums in 2013 were about $225, and today they are about $475, which if you think about that, 85 percent of people were covered before the Affordable Care Act.

We have succeeded in covering 6 percent more people. So the cost of that, though, was those 85 percent, who were already covered, have to pay more than twice as much to pick up that incremental benefit of the 6 percent more people.

Now, there are different ways to cover those 6 percent more people. Most of those people were picked up because we expanded Medicaid in most States. And so we just basically said, here, here is your free insurance, and we picked those up. We didn't have to charge everybody else twice as much to get most of that incremental benefit.

We could have just said, we are going to expand Medicaid, forget about the rest of the Affordable Care Act, right?

Most States had other mechanisms for covering people who had preexisting

conditions. My State, South Carolina, had a health insurance pool. I am curious about Oregon -- and, Mr. Stolfi I am going to pick on you, because you are the only insurance commissioner here. What was Oregon's mechanism for covering people with preexisting conditions? Did they have one? Did you have none?

RPTR FORADORI

EDTR HUMKE

[12:00 p.m.]

Mr. Stolfi. Thank you, Representative, Oregon did have a high-risk pool program.

Mr. Rice. And could people be excluded from the high-risk pool?

Mr. Stolfi. There were waiting lists for the high-risk pool. There were preexisting exclusions for the first -- it could be up to 6 months.

Mr. Rice. Okay. But we have open enrollment for a limited period of time in ObamaCare, so if you want to sign up in May you got a 6-month waiting period anyway, right? So that really hadn't changed.

Now, how much more was the monthly premium in Oregon for a high-risk pool, people with preexisting conditions, than for other people? Was the premium a whole lot higher? In South Carolina I know, because I had two kids that were on our high-risk pool, I had one that had a heart defect and one that had a brain defect, and the premium in South Carolina was about 30 percent higher. How much more was it higher in Oregon?

Mr. Stolfi. It was capped at 125 percent of the cost.

Mr. Rice. So it was 25 percent higher, right?

Mr. Stolfi. Yes.

Mr. Rice. Okay. Well, today, I am telling you, there is it is right there, everybody has to pay 230 percent more because of ObamaCare. Now, if before ObamaCare the people -- the most risky folks with preexisting conditions had to pay 125 percent and their deductibles had now gone up like five times, I mean, I looked at your plan, you had a $750 deductible, a $500 deductible, and a $1,000 deductible -- I mean, $1500 deductible. Now you are average deductible is $4,100.

So your people with preexisting conditions are now having to pay 230 percent more

or 130 percent more instead of 25 percent more, and their deductible is five times as much. Can you really look at me with a straight face and tell me that those people are better off with ObamaCare than they were before ObamaCare? They had lower premiums. They had access to coverage. And they had much lower deductibles. Are they really better off? Do you really believe that?

Chairman Neal. The gentleman will be allowed to finish his answer, please.

Mr. Stolfi. Thank you, Mr. Chair. Absolutely, the people are better off now than they were before. And you touch on a point of affordability, which is a very important concept. And there is many different ways to look at affordability, and one is, you know, for the people that don't have choice. The people who have health conditions, how affordable is this coverage for them? Before the ACA, this coverage was not affordable for people. If they --

Mr. Rice. It cost half as much. It cost half as much.

Mr. Stolfi. So we have compared the price right now of an average comprehensive healthcare plan that any individual can get now to the price that someone would pay in OMEP, and those prices are essentially the same. Actually, the OMEP policy is --

Mr. Rice. But the price you are comparing it to is 230 percent higher than it was before ObamaCare drove it up.

Mr. Stolfi. So the price differences have actually have happened, can't dispute that. But what is very important is that we are not comparing apples to apples.

Chairman Neal. The time of the gentleman has expired. We move to Ms. Sanchez to be recognized for 5 minutes.

Ms. Sanchez. Thank you, Mr. Chairman. And I want to thank all of our witnesses for joining us today.

I am extremely pleased that we having this hearing on preexisting conditions

because it is a reminder of the measurable improvements that have been made in the lives of millions of Americans since the passage of the Affordable Care Act.

And I have personal experience with this with staff members that were employed in my district office. I know for a fact that prior to the ACA, insurance companies could deny anyone coverage for any reason, and they could also discriminate against women and charge us higher premiums simply because of our gender, because we are women. That is a practice known as gender rating, which I was proud to have championed its demise in the passage of the Affordable Care Act.

In 2009, a study by the Women's Law Center found that young, healthy women, were charged 84 percent more than similarly aged males for plans that didn't even include maternity benefits. Insurance companies treated being a woman effective as a preexisting condition. Before the ACA many with health insurance who thought they had coverage often found themselves denied coverage in their time of need. Many were shocked to find that maternity care wasn't covered under their plans or they were denied coverage entirely after a pregnancy.

But it is not just women who benefitted from the Affordable Care Act. More than 130 million Americans have a preexisting condition and are now guaranteed access to coverage and quality affordable care when they need it. I am proud to have worked on and voted for the Affordable Care Act. And I am frustrated by Republican efforts, namely, efforts by this administration, to increase costs and decrease quality. While they love to attack the ACA, what they do in response to that is create more uncertainty and drive up prices.

So I am interested, Ms. Pollitz, I have a few things that I am interested in asking you whether or not doing these things creates more certainty, and thus makes healthcare coverage more affordable because these are things that we have seen. Refusing to use

appropriated money to do advertising, outreach, and hire navigators to explain enrollment processes. Do you think that creates more uncertainty and helps lower healthcare costs?

Ms. Pollitz. I think that does make it harder for people to know all of our polling that we have done every year, at open enrollment shows that people don't understand the ACA still, or when the dates are. So not having advertising and consumer assistance can make it harder for people to sign up. The healthiest people are the most likely to stay out.

Ms. Sanchez. Ms. Brooks-Coley, do you think that that helps creates more certainty and lower healthcare costs by refusing to use money to the outreach and hire navigators?

Ms. Brooks-Coley. No from our perspective, transparency and education about plans and what type of coverage an individual can purchase is extremely important. And not having the funding used for that purchase can lead to patients not actually purchasing insurance or understanding what they are purchasing.

Ms. Sanchez. Okay. Ms. Pollitz -- and, Mr. Blackshear has personal experience with this, perhaps you would care to chime in -- allowing these substandard junk plans to be sold on the market, do you think that that creates certainly and lowers costs?

Ms. Pollitz. That has been shown to increase costs. Insurer rate filings show that they expect this will cause adverse selection, and so raise the average cost of the ACA compliant plans.

Ms. Sanchez. Mr. Blackshear.

Mr. Blackshear. I just want to say, it literally does increase uncertainty.

Ms. Sanchez. Thank you. What about challenging in court critical provisions of the ACA such as penalties for those who don't get coverage or striking down the individual mandate? Ms. Pollitz.

Ms. Pollitz. That is another source of uncertainty about the future of the ACA.

Chairman Neal. Mr. Stolfi, would you agree with that?

Mr. Stolfi. I would agree yes.

Ms. Sanchez. Thank you. Finally, Ms. Pollitz, could you explain what would happen if we rolled back the preexisting condition protections and the gender rating provisions? What would that happen -- what would happen to those seeking coverage?

Ms. Pollitz. Well, that would be kind of going back to what the world looked like before 2010. So that women in -- certainly younger women would pay much more in premiums than younger men due to gender rating, and people with preexisting of conditions or a history of them, would find it much more difficult to find coverage in the nongroup market.

Ms. Sanchez. I just want to state for the record in the limited time that I have. I had a staff member who worked in my district office, mother of four children, who got cancer, and this was prior to the passage of ACA, and they refused her care at a certain point because she had hit her cap. And so she was not able to get treatment, and sadly, she passed from cancer. That is what will happen if we roll back the protections in the Affordable Care Act.

And, again, I want to thank the chairman, and I want to thank our witnesses.

Chairman Neal. Thank the gentlelady. With that, let me recognize the gentleman from New York, Mr. Higgins, to inquire for 5 minutes.

Mr. Higgins. Thank you, Mr. Chairman. Prior to the enactment of Medicare in 1965, 56 percent of older Americans could not get coverage because they had the preexisting condition of old age. That is when the Medicare program was established. Today, 97 percent of older Americans have access to good quality healthcare through the Medicare program.

Preexisting conditions is basically good people that are treated differently by

private insurance because they were born with a genetic mutation that causes or increases the risk of disease. Those diseases include childhood cancer, juvenile diabetes, kids born with Downs syndrome, cystic fibrosis. Before the Affordable Care Act, almost 50 percent of adults between the ages of 50 and 64 1/2 tried to buy health insurance for them and their families, and they were denied because of preexisting conditions.

You can't do that anymore. It is against the law because of the Affordable Care Act. My colleagues on the other side keep saying that everybody up here supports preexisting condition protections, that is not true. Everybody up here does not support preexisting condition protections. House Republicans between March of 2010 and July of 2017, more than 7 years, House Republicans voted 70 times -- 70 times to repeal and replace the Affordable Care Act's preexisting conditions protections.

Everybody up here does not support people with preexisting conditions. Having failed 70 times, Republicans then advance their new plan. The insidious, malicious language in there said that you had -- a health insurance company had to write a policy for somebody with preexisting conditions, but that policy didn't have to cover the treatment of a family member, a kid who is stuck with childhood cancer for that preexisting condition. So, no, everybody up here does not support protecting people with preexisting conditions.

Mr. Brady. Will the gentleman yield?

Mr. Higgins. I will not yield. I will not yield.

Mr. Brady. I Yield back.

Mr. Higgins. So House Republicans couldn't pass legislation to repeal and replace. They couldn't pass their own healthcare plan because nobody supported it because nobody believed them. So then they went to the States and they said they will do what we were unable to do. Twenty States attorneys general joined a lawsuit challenging the Affordable Care Act in the preexisting conditions protections in Federal court. Eleven

of those States have the highest population of preexisting conditions.

So the only hope left is the White House, and the White House's Justice Department who can come in and save the day. They filed an opinion saying that they would not defend the Affordable Care Act, and that they opposed and characterized it as unconstitutional. The preexisting conditions protections of the Affordable Care Act.

Nobody up here, not one person up here, supports preexisting protection for the American people. Not one person up here. And not one Republican out there either. You go ask the States attorneys general in those States that have joined together to fight this protection that people fundamentally need.

Here is the bottom line. The Medicare program did what private insurance companies had the opportunity to do and decided not to, because they don't make a lot of money on people who are sick. That is not who we are as a Nation. That is why we should allow people to use the leverage of the Medicare program to buy-in at their own expense so that they can get the protection of preexisting conditions now.

The private sector has had all kinds of opportunity. And the great irony in all of this is that Medicare was established as a public program, and guess what, when it was so successful, guess who wanted to get involved? Private insurance through Medicare advantage.

Look, I think the choices are pretty clear here, and I think that we will have legislation that will affirm in clear and unambiguous language.

Mr. Brady. Mr. Chairman, regular order -- stay on the time --

Chairman Neal. I thank the gentleman. His time has expired.

Mr. Higgins. We have preexisting conditions. I yield back.

Chairman Neal. With that, subscribing and adhering to what is known as the Gibbons Rule, for some of us who have been here for a bit, we will recognize the

gentleman from New York. And the Gibbons Rule simply says people are recognized in the order in which the gavel came down if they were seated. Mr. Reed.

Mr. Reed. Well, I thank the chairman for the recognition. And with great respect and to my colleague from New York who just articulated one of the greatest falsehoods I have ever heard uttered in this chamber on the Ways and Means Committee. Republicans and the gentleman, I would hope, would remind himself that he is a Member of Congress. And as a Member of Congress, I stand here to articulate as a Republican, and as a member of this dais on the Republican side, that we take yes for an answer.

We support the provision. The provision. Remember, the Affordable Care Act was 3,000-plus pages. And the provision that we are talking about, the protection of preexisting condition is something where I say to the American people and I say to this dais and I say to my colleagues on the other side of the aisle, take yes for an answer. We agree with you. This reform is good. This reform will stay as the law of the land.

And we heard the voice and the fear that was the result of the 2018 election where this issue became centerpiece in that vernacular and in that debate, that we listen to the American people as Republicans. Preexisting condition will remain the law of the land. But we need to do better. And what I would articulate to the American people today is that there is a fundamental choice that is going to be on display for you for the next 2 years.

The fundamental choice that is carried by my colleagues on the other side of the aisle is known as something as simple as Medicare for All, single payer healthcare. What that is is government control, government run healthcare. We as Republicans offer you a different vision. We offer you an embrace of market pressure to bring healthcare costs down, that will also bring health insurance premiums down.

So, Mr. Blackshear, I heard your story, I heard your condition. And maybe if I

could articulate something that I have seen repeatedly as I have gone across my district and across this country and talked to American people, there is a vast misunderstanding in regards to the connection of healthcare cost and health insurance premiums.

I heard your testimony, and if I heard it correctly, you said your premiums now are about $70 to $80 a month. Is that correct?

Mr. Blackshear. That is correct.

Mr. Reed. So that is approximately $1,000 a year. And your horrific preexisting condition, your horrific heart condition, I read your testimony, and it articulated that you had exposure to medical costs of $200,000, and probably those medical costs were triple that, quadruple that. A million dollars for the care that you received.

And so do you see the issue between $1,000 a year versus the cost of care that your horrific condition of $200,000 plus causes? And what we in the healthcare arena have to have a vehicle to take those costs, right, of $200,000 plus for your condition, and if you are paying $1,000 a year in premiums, how does that cover the two together?

And I think what Mr. Robertson is offering, from Nebraska, is a way to do that. Are you not, sir?

Mr. Robertson. Yes.

Mr. Reed. And how do you do that?

Mr. Robertson. Again, forming an association health plan you pool the individual small markets together so basically you can cover people with preexisting conditions because your risk pool is large enough to do that. That is what large employers do today.

Mr. Reed. And that is what employers do. So what it is about is taking those costs, right? And it is trying to share them amongst everyone. But most fundamentally, I think what is lost in this debate is -- did anyone here today testify to any mechanisms to bring those healthcare costs of $200,000 down? I did not see any of your testimony

talking about how to bring that $200,000 price tag that Mr. Blackshear was exposed to. Did I see any testimony offered by anyone in here about bringing those costs down? Did I miss it?

And the silence of the dais speaks volumes to the issue that we face. Because, Ms. Brooks-Coley, I heard your testimony, and we talked about exorbitant prices, and my colleagues question to you was about premiums. You didn't talk about the premiums, you talked about the prices, and you kind of mixed the two together. Did I hear your testimony correctly?

Ms. Brooks-Coley. You are referring specifically to high-risk pool premiums?

Mr. Reed. He asked you about exorbitant premiums and you talked about exorbitant prices. So, to me, that was your testimony to me to bring prices down is where the focus should be. And that is where agreement and common ground could be found.

With that, I yield back.

Chairman Neal. With that, the gentlelady will be able to answer.

Ms. Brooks-Coley. Well, the only thing I would say is from the cancer perspective, we have concerns about the rising cost of premiums as well as the out-of-pocket costs for patients. And we agree that affordability is an issue, but you have to look at ways to address affordability without addressing and harming patient access to comprehensive coverage. You look at plans such as short-term limited duration plans and other products that aren't comprehensive, that is where we become very concerned.

Chairman Neal. Thank you. With that, let me recognize the gentlelady from Alabama, Ms. Sewell, to inquire for 5 minutes.

Ms. Sewell. Thank you, Mr. Chairman. I want to commend you for having our first hearing to be about preexisting conditions. As has been stated before, preexisting conditions affect over half Americans. And as my colleague, Ms. Sanchez, said, the

gender rating affected women and made being a women a preexisting condition. I can also tell you that the ACA has not only helped us in making sure that insurance companies can no longer discriminate against Americans for preexisting conditions, but it also decreased the incidences or the cost of being sick while black.

So as a black woman, I have seen the ACA work both to reduce the incidence of gender but also help to reduce some of the barriers to access that often people of color have.

My question really, I guess, is to Ms. Pollitz. Can you talk a little bit about the access to the barriers to healthcare like, for example, not expanding Medicare -- Medicaid. There are lots of States like mine, Alabama, that did not expand Medicaid, and the premium costs have skyrocketed, not just because of, you know, the fact that not as many people are signing up for the healthcare insurance, but the fact that so many folks just can't afford the premiums and the deductibles.

Can you talk a little bit about access to healthcare and how the ACA has affected that?

Ms. Pollitz. Sure. So about 2 million people live in -- adults, below poverty, live in States that have not expanded Medicaid. So they don't have any affordable insurance options available to them.

Ms. Sewell. And isn't it true that by decreasing the subsidies, which was one of the ways that my colleagues across the aisle sabotaged the ACA, that that only exacerbates the problem?

Ms. Pollitz. There is actually a proposal the President just released in the 2020 benefit and payment parameter rule that actually would reduce subsidies under the ACA, just by changing the formula that indexes what people have to pay and how much subsidies they get. That is expected to save the Federal Government about a billion dollars a year,

and --

Ms. Sewell. Expanding Medicaid or creating --

Ms. Pollitz. No, I am sorry, that is to reduce the ACA subsidies. And another -- the administration estimates about 100,000 people would lose coverage as a result of that.

Ms. Sewell. Well, I know that in my State we don't have -- our farmers struggle oftentimes with finding affordable healthcare. In fact, there is a farmer in Nectar, Alabama, Hank Adcock, whose story I have shared in this hearing before. He never had -- he is a third generation farmer, has never had health insurance until a navigator knocked on his door back in 2015. And, you know, had the navigator called it ObamaCare, he said that he probably wouldn't have gotten the health insurance. But because they said it was the Affordable Care Act and because it was an affordable subsidy that he was offered, he took health insurance.

Almost 6 months later, his hand got caught in one of those hay bailers and, you know, not only did the Affordable Care Act save his hand, it also saved his farm because he had health insurance for the first time ever. And so, you know, unlike Mr. Robertson, unlike the association plan that you discussed for your farmers, we didn't have that option in Alabama. And Alabama also did not expand Medicaid, and so, so many low income workers and hardworking families are struggling just to find access. So I really wanted to talk about cutting down the costs.

Wouldn't it be better if we expanded access to coverage like you have done in Oregon through your own devices. I wanted to talk to Mr. Stolfi about how we can decrease the costs, because we have heard a lot about that. How has your State decreased the costs and at the same time expanded access?

Mr. Stolfi. Thank you, Representative. Cost is definitely one of the key issues

and something that we all should be focusing our time and attention on. In Oregon, we have taken a couple approaches -- well, there are a couple of major drivers of cost. Prescription drugs are a major driver of cost, utilization is a major driver of cost. Uncoordinated care and unhealthy behavior all contribute to cost. And --

Ms. Sewell. I am going to reclaim my time because I only have 7 seconds, just to say that your testimony -- your written testimony goes into detail about that, and I refer us all to that.

I wanted to mention, Mr. Chairman, that the Black Lung Disability Trust Fund, which was established 40 years ago and pays benefits to coal miners who have had total disabilities, an excise tax on coal that we supported for this fund has expired, it expired last year.

And I just wanted, as a State, Alabama, who has lots of coal miners, many of whom are out on disability because of that, I would love for this committee to either have a hearing and definitely hear from them as to why it is so important that we reestablish this excise tax.

Chairman Neal. I thank the gentlelady. I will make sure that the staff follows up with you.

With that, let me recognize the gentlelady from Washington State to inquire for 5 minutes. Ms. DelBene.

Ms. DelBene. Thank you, Mr. Chairman. And thank you to all of our witnesses for being with us today. Ms. Pollitz, I want to make sure that it is clear what is covered by a qualified health insurance plan that is sold on the Affordable Care Act exchanges, and what could possibly be missing from a short-term limited duration plan.

And I have a constituent, a nurse in my district, she has a young son, Sammy, who has hemophilia, and her employer-sponsored insurance is very critical. But if she lost her

job or could no longer work, first of all, would she qualify for a special enrollment period?

Ms. Pollitz. In the marketplace, yes, she would.

Ms. DelBene. Yes. And if during that special enrollment period she purchases a plan for her and her son, would all the plans sold on the ACA exchanges guarantee coverage for hemophilia?

Ms. Pollitz. Yes.

Ms. DelBene. And if she purchased a short-term limited duration health plan, would she be guaranteed coverage for hemophilia for her son?

Ms. Pollitz. She would not be able to buy that policy for her son. She would be turned down.

Ms. DelBene. She would not have coverage?

Ms. Pollitz. Correct.

Ms. DelBene. Yes. If a young man in my district who turns 26 and can no longer stay on his parents' plan, he would also then qualify for special enrollment period. If he has Type I diabetes and he goes to buy coverage on the ACA exchange, would he have coverage for his diabetes?

Ms. Pollitz. Yes, he would.

Ms. DelBene. Would he be guaranteed coverage for his diabetes if he buys a short-term limited duration plan?

Ms. Pollitz. He would not be able to buy one. He would be turned down.

Ms. DelBene. So another example, say, a graphic designer who has Lupus decides to quit her job and start her own small business. If she buys on the ACA exchange, is she guaranteed that her Lupus would be covered by that plan?

Ms. Pollitz. Yes.

Ms. DelBene. And if she would have that same -- would she have that same

guarantee for coverage of her Lupus if she acquired a short-term limited duration plan?

Ms. Pollitz. She would not be able to acquire a plan. She would be turned down.

Ms. DelBene. So and finally, the ACA included a provision that required all qualified health plans to spend 80 cents of every premium dollar on healthcare. If the plan spends less than that, they have to return some money to the beneficiary. Does short-term plans have that same financial protection for consumers?

Ms. Pollitz. No, they do not, and they tend to have much lower medical loss ratios.

Ms. DelBEne. Do you have examples of what those might be?

Ms. Pollitz. Closer to 50 or 60 percent of premium dollars are spent on claims as opposed to admin and profits and other --

Ms. DelBene. So there is quite a stark difference between what qualified plans cover and what short-term limited duration plans covers, isn't there?

Ms. Pollitz. That is correct.

Ms. DelBene. Thank you so much for your feedback.

And, Mr. Chairman, I yield back.

Ms. Sewell. [Presiding.] The gentlelady yields back. And the chair recognizes Mr. Schweikert from Arizona.

Mr. Schweikert. Madam Chairwoman, you look good in that seat. All right. Let's actually walk through a couple things. First, to our witness from Kaiser, thanks to much of your staff, they were incredibly helpful to my office over the last couple of years, particularly as we worked on the invisible risk pools, the math. I know what you do data-wise is very difficult because you do a lot of your data out of survey instead of actually getting actual hard data from insurers and those. I am hoping over time we can find a way so you can have even crisper data.

To the gentleman on the end who also has had valley fever. You had undifferentiated. A couple of us actually chair a valley fever task force. Be joyful, we think in 4 to 5 years we will have a vaccine out for animals, and then a little time after that, humans. But it has been a fixation for many of us from the desert southwest. Most people have no idea the orphan disease, that is this fungi, that affects so many people. So I share that with you.

I am trying to find an eloquent way to say -- I am frustrated because I know everyone here is sort of speaking from their heart and their knowledge-base. Much of my life has actually been in the financing side on some of the healthcare, and how do you do the actuarial math and how do you make it work.

A year ago, we actually -- not only when you look at our Republican legislation, we had in their guaranteed issue, and we can all have a conversation, sort of the mechanisms of what is guaranteed issue and what is preexisting. They actually sort of partially overlap, there is some structural differences.

But we also added another $15 billion to buy-down in the individual risk pool some of the actuarial toxicity, because let's face it, it is 5 percent of our population, that is a little over 50 percent of all of our healthcare spending, because there are brothers and sisters with chronic conditions.

So here is my argument to both my friends on the left, the right, and anyone that might be in between. We are having the wrong conversation here. Think about what we are doing. We are talking about, well, this is preexisting, well, this isn't. Well, this is -- we can do this with premiums, but we will subsidize it more over here. The quick thought experiment, pre-ACA, after ACA, Republican alternatives, this and that.

If you were to take all dollars we are spending in our society, in our country, all dollars, whether it is coming through government, whether it is coming through your

insurance premium, out of your pocket, have we done anything to actually change the cost curve? All we are really debating here is who gets to pay.

And if you actually go back over the years of, you know, going back to 1986 when we had sort of guaranteed service at an emergency room, or 1996, you know, when we actually did HIPAA, which actually had lots of the guarantees and the protections or the ACA. We have been just moving around the deck chairs on the ship.

I will ask from my Democrat colleagues, from my Republican colleagues, it is time for a radical rethinking of are you willing to work with us to break down the barriers to have a cost disruption? When this is about to become your primary care physician. When the technology -- when I can show you the thing that looks like a large kazoo that you blow into, it tells you if you have the flu, the handheld ultrasound. There is a revolution rolling out right now and we have lots of statutory barriers at our State levels, our Federal levels, even in the original Social Security Act, that will keep technology from rolling out, empowering us to take better care of ourselves and crash the price of healthcare. And that is the more elegant debate here.

Is we can continue this sort of circular logic we are having in these debates of well, you support preexisting conditions, well, I support preexisting condition coverage. Back and forth, and it is great politics. And we are doing nothing to crash the price. It is basically your Blockbuster video moment. Is there is technology rolling out that should help us crash the price.

Now, how many of the smart people sitting here at the dais could start to design plans using that technology, using these opportunities? And we are going to have to have some really difficult conversations of do we have substantial overcapacity in physical structures? Well, we have lots of reports. Kaiser has actually done a couple of them of the number of hospital beds in the Nation that are actually empty and the caring costs of

those. These are difficult conversations because we love our hospitals, we love -- but there is technology revolutions around us, and unless this committee and others around us start to break down these barriers, we are going to continue in the circular logic over and over. There is a chance to do a cost disruption. Let's actually start to embrace it and do something actually good.

Thank you, Madam Chairman.

Ms. Sewell. The chair recognizes Ms. Chu from California.

Ms. Chu. Well, I am particularly concerned about what would happen to women's health if we did not have the ACA.

So, Ms. Pollitz, I am concerned that the actions taken by the Trump administration will fundamentally undermine one of the ACA's core tenants, the support of cost-free preventative health services. And one of the most impactful is that of the birth control benefit or the Affordable Care Act's requirement that plans must offer no cost contraception coverage.

Since the ACA went into effect, about 63 million women have access to this healthcare benefit. And I feel I must emphasize this because it so often gets wrapped up in policy debates that people don't consider birth control to be healthcare, but it is healthcare plain and simple. But if the case in Texas prevails, this benefit, like the rest of the ACA, will be eliminated.

So, Mr. Pollitz, can you discuss what the situation was for contraception coverage prior to the ACA? Were there groups who were more likely to not have access to contraception or be unable to afford it?

Ms. Pollitz. I believe our women's health team has some -- a brief on this, which I would be happy to look up and submit for the record. In general, the big change with ACA was to require the no-cost coverage, so no deductibles, no co-pays apply for

FDA-approved methods of contraception. So that has been -- taken down a cost barrier for many women.

Ms. Chu. Okay. Thank you for that.

Ms. Brooks-Coley, thank you for testifying today on behalf of cancer patients amongst American women. Breast cancer is the most commonly diagnosed cancer, and the second leading cause of cancer death. In 2016, 3.5 million women in the U.S. were living with a history of breast cancer.

So, Ms. Brooks-Coley, can you describe the provisions in the Affordable Care Act that helps women detect breast cancer early when it can still be treated, and what would happen to women with breast cancer if the ACA were repealed?

Ms. Brooks-Coley. Thank you, Congresswoman. The Affordable Care Act made sure that women who actually are diagnosed with breast cancer have access to comprehensive coverage. One of the things that it also did for all Americans and all women was to make sure that preventative services are available to individuals for free or little cost.

We know that important preventive screenings such as mammography, colonoscopy, can be lifesaving tools that allow an individual to actually have their cancer diagnosed early, where we know then that the diagnosis and treatment then can lead to better survival rates and better survivorship.

Ms. Chu. Thank you. I am also concerned about what would happen to low income women on Medicaid if the ACA were to end.

Ms. Pollitz, I am deeply concerned about the Medicaid population. Medicaid provides 75 percent of the funding for all family planning services, nearly half of all births, and half of all long-term care funding, which many frail elderly women on Medicaid rely on. Medicaid is a lifeline for millions of American women, and Republican actions to

have put in lifeline in jeopardy.

So, Ms. Pollitz, can you please discuss what the implications would be for women in the Medicaid program if the entirety of the ACA were to be struck down?

Ms. Pollitz. Well, the Medicaid expansion, which covered adult women who were not pregnant or mothers of dependant children, and who had income up to 138 percent of poverty. So the Medicaid expansion has been the engine of insurance expansion in the ACA. And if that were to go away, then millions, millions of women with -- low income women would lose coverage.

Ms. Chu. And, Mr. Stolfi, I want to ensure that women would not be left unprotected through inadequate junk plans. My State of California joined five others in limiting or prohibiting the sale of short-term limited duration plans or the junk plans, and while they may appear to have lower premiums, many consumers find themselves stranded when they don't offer coverage for some of the most expensive conditions like pregnancy.

What is some of the additional actions that States like California can do to protect consumers, especially women, from efforts to undermine the ACA?

Mr. Stolfi. Well, yes, specifically in regard to short-term plans, other States could do exactly what California has done and prohibit them. What Oregon has done and restrict the amount of time that they can be sold. Other States have done this through regulation. We would appreciate further guidance at the Federal level reversing the Federal rule changes. Even in States where we have not taken on those changes, it has created uncertainty and added costs -- unnecessary costs to our folks. So we would appreciate more certainty there.

Ms. Chu. Thank you, I yield back.

Ms. Sewell. The chair recognizes the gentlelady from Wisconsin, Ms. Moore.

Ms. Moore. Thank you so much, madam chair. And, again, I am just really glad

to be here. I just want to say to our witness from the Farm Bureau that I want to commend you for pooling together the 700 people in the association to provide them with affordable healthcare.

And while those 700 people can have some reassurances about their healthcare, the Affordable Care Act sought to do that and did do it for 20 million additional people. It was the very same concept of pooling the risk, bringing in young people like Mr. Blackshear, who were healthy at the time, having them pay a premium so as to lower the cost for everybody.

And as a matter of fact, before we started giving it names like the Affordable Care Act and so on, and the ObamaCare, it was RomneyCare. It was the best of market ideas of the insurance industry. Get a risk pool. And it was not Medicare for All, it was the combination of a social goal of insuring as many people as possible with a market driven pathway.

So for those people who are looking for ideas, let's just go back to RomneyCare. Now, I guess the question that I have for you, Ms. Pollitz, and keeping in mind the testimony that we have heard from Mr. Robertson. If Nevada didn't have affordable care, could it be because of the some of the things that this body, Congress, the majority under the Republicans did to undermine the affordable healthcare. I am thinking back to the $12 billion in risk sharing that, you know, while we were trying to stand up the Affordable Care Act, there was $12 billion that we didn't give to the insurance companies to eliminate that uncertainty.

I am thinking about not expanding Medicaid in places like Nebraska, which raised the cost of healthcare to everybody. I am thinking about reducing advertising to people. I am talking about pushing out these short-term limited duration insurance policies, which don't provide minimum care.

Cutting subsidies they did last year, how have these impacted on people to the extent that folks that are in the association health plans couldn't find good care, and what is the difference between the association healthcare and the affordable healthcare?

And I will yield to you.

Ms. Pollitz. The changes that you -- the actions that you talked about in different ways contributed to kind of an artificial increase in the cost of marketplace plans.

Ms. Moore. And some insurers just disappearing from the marketplace all together.

Ms. Pollitz. Correct. That is correct. So the uncertainty, as I mentioned in my oral statement, really has been kind of a common theme of changes, actions taken, that have driven up marketplace premiums. Marketplace premiums in Nebraska, for example, silver loading. The benchmark plan in Nebraska is dramatic. The benchmark silver plan costs about 40 percent more than the cheapest gold plan in Nebraska. So it is -- right? That is just an artificial kind of price action that the insurers had to take to back up.

So as long as people are eligible for subsidies, they don't feel that, the taxpayer picks that up. And it sounds like many of the members in Mr. Robertson's plan are not eligible for subsidies, so they would feel the full brunt of this. Just one other thing on pooling. It has just come up a couple of times, and I kind of wanted to comment on it.

The pooling itself doesn't make insurance cheaper, it just kind of spreads out the costs, it redistributes, so everybody kind of pays the same share. If you pull out a small number of people from the marketplace who are healthier than average, then that also has an upward pressure on the average --

Ms. Moore. Thank you so much. Reclaiming my time. I just want to go back to the old axiom dating back to 1692, Gersham Bulkeley, that says that actions speak louder than words. So while we all say we are for protecting preexisting conditions, I think that

the sabotage we have seen does not hearken well. Actions speak louder than words.

And if we were trying to provide healthcare to people, we would not be undermining this market-driven proposal that we have, the Affordable Care Act.

And I yield back.

Ms. Sewell. The chair acknowledges that votes have been called to members. There is only one vote. We are going to continue to go. So the chair recognizes Mr. Wenstrup from Ohio.

Mr. Wenstrup. Thank you, madam chair, I appreciate it. It has been in interesting morning, obviously, and I am glad that, I think, deep down we all agree we want coverage for preexisting conditions. We have had many little history lessons today, true or otherwise. But the fact is that we as Republicans have pledged support for coverage for preexisting conditions included in our bill.

I have a family member that has a preexisting condition that will need care her entire life. We all get it. There is no part about me as a doctor -- and, by the way, I came here for many reasons. I ran for office for many reasons, but in part to stand up for patients. There is no part about me as a doctor that doesn't want our fellow Americans to have access to quality affordable healthcare, all Americans.

I want Medicaid to be a better program than it is. I want all of our plans to be able to take care of people and have a way for people to get into care. And, frankly, I applaud the Obama administration because they took the issue on. It should have happened sooner. But I don't necessarily agree with the direction that it went.

And, by the way, I heard President Obama one time say he was very fond of it being called ObamaCare because it put his name with the word care every time someone said it, and I don't blame him. It is a pretty good marketing tool. And I hope the members of this committee will come forward with more to offer than just trying to scare

Americans with the false claim that we don't want people with preexisting conditions to be covered. Is that what we are going to sit here and do for the next 2 years? I certainly hope not.

The Affordable Care Act has helped some people. That is a fact. We get that. For many, it did not. That is also a fact. I was in church, small town in Ohio, the pastor was asking for donations to help the poor, and a woman said, pastor, you don't know what it is like out here right now. What I am paying for healthcare today is through the roof, and God forbid if I get sick, because I can't afford that either. And that is in part because of her deductible.

A primary care doctor in the same community quit taking insurance because if he didn't have to go through the rigamarole of insurance, he then could cut his cost. And since people are paying out-of-pocket because of their high deductible, he cut the price down and he eliminated the paperwork. That is what is happening in reality, folks. And you can talk about all this here today, but there are flaws in the Affordable Care Act that it is making it more difficult for patients to get care. And at the same time, they are budgeting with their healthcare. That is a problem when you put things off because you can't afford it because of your high deductible. And you can barely afford the premium, if you are even getting it because the premium is so high.

So, yes, they do seek some of these plans where they wouldn't take you with preexisting conditions, but then they hope they have something just in case, in case there is an unavoidable catastrophe. I would like to have all of you back here some time to talk about incentivizing health. What do we have in our market today? What do we have in our plans today that are incentivizing health, not only for the patient but for the physician.

We talk about lifespan. We talk about how people live longer in America, although because of our drug program that is going down, unfortunately, our lifespans.

Let's focus on our health span. Ms. Pollitz, you talked about treatments. We have been great at treating things, but what have we prevented.

Think about this. Think about who gets rewarded in today's system. You know if you are the open heart surgeon that saves someone's life, yeah, we want that ability to be there, of course, and we want people to have access to that. But do we recognize any of the physicians that worked with the patient that presented him from needing the open heart surgery. That is where we need to go, folks.

If you want to talk about a cost curve, start preventing. So I hope that we can come back and have solutions for this committee so that maybe we can enhance things that will incentivize health in America. That is where we are going to save. That is where the cost will go down. And I want that so that we will have a robust care system for those that have something that can't be prevented. And I would hope that you all agree with me on that. This is about patients, not politics.

Let's cut the politics in this committee and let's focus on what is best for patients and people and their families. With that, I yield back, and I hope to see you again to discuss that issue.

Ms. Sewell. To allow members to vote and to allow the witness to take a break, we will have a recess until 1 p.m.

[Recess.] 1 p.m.

Chairman Neal. [Presiding.] Let's reconvene the hearing. And I believe that Mr. Boyle is next to inquire. I recognize the gentleman for 5 minutes.

Mr. Boyle. Thank you, Mr. Chairman. And just to briefly follow up on what the gentlewoman from Wisconsin was talking about in terms of the roots of the Affordable Care Act, RomneyCare. I would just point out, the first time I ever heard the concept was from a professor, he was a fellow at the Heritage Foundation named Stewart Butler, who

was one of the founding fathers of this idea. The Heritage Foundation, not exactly known for its bleeding heart liberalism. And then the roots of the Affordable Care Act were originally introduced in the Senate by Bob Dole and 17 Republican Senators.

Unfortunately, then when President Obama and the Democratic Congress championed it, suddenly the view on the other side changed. But having just spent or endured the last 8 years of an attempt to repeal the Affordable Care Act, and having seen that defeated legislatively, I am very concerned that what couldn't be achieved legislatively now might be achieved judicially.

We had very recently an activist judge in Texas strike down the Affordable Care Act, even though the Supreme Court had affirmed the Affordable Care Act a number of years ago. So could you talk to me, and I will turn to Ms. Pollitz. If you could -- if the 18 States attorneys general are successful ultimately in their lawsuit and higher courts affirm the lower courts' ruling and provisions of the Affordable Care Act are scrapped, what would that mean for those who currently absolutely need a policy that they have gotten from the Affordable Care Act to live or have certain protections in their already existing private plan that came about because of the Affordable Care Act, such as the one on preexisting conditions?

Ms. Pollitz. Well, so that would roll the clock back to pre-2010. The Federal law prohibition on discrimination against preexisting conditions would go away. In a number of States that prohibition has been enacted in State law, so at least for people in State-regulated policies that would continue, but the Federal subsidies would also go away, and that is what really helps keep the market stable.

States that tried, before the ACA, to prohibit discrimination based on preexisting conditions without subsidies found that there were adverse selection and there were rate spiral problems. And then other provisions covering kids to 26, the Medicaid expansion

for poor adults, prevention -- and the prevention trust fund, the FDA authority to license biosimilars, the ACA ended up including a wide number of provisions that really affect all Americans.

Mr. Boyle. And I am glad that you point that out because often coverage of the ACA just focuses on the marketplace and doesn't focus on those other provisions. One that you spoke about, I just wanted to key in on the Medicaid expansion. That was one of the best bangs for our buck, so to speak, in terms of expanding coverage to those who didn't have it.

Now, because of the U.S. Supreme Court decision, States had the ability to opt-in or opt-out, so we haven't been able to get Medicaid expansion throughout the country. If, ultimately, the Affordable Care Act were done away with, what would happen to those who got their healthcare through the Medicaid expansion since that was one of the biggest boons for us?

Ms. Pollitz. Right. So States -- let's see. States -- well, first of all, States would lose the Federal money.

Mr. Boyle. Which is currently 100 percent or has it dropped to 90 percent?

Ms. Pollitz. It is on its way to 90 percent. It is below 100 percent now and it will be at 90 percent next year. So billions of dollars in Federal dollars would go away. But under Federal law, Medicaid was a categorical program. It was -- and Federal matching was only for poor people in certain categories, you know, children, pregnant women and so forth. So millions of people would lose coverage if that Federal law change were to go away.

Mr. Boyle. And when we talk about millions of people, it is not just the overall number, we are talking primarily about the working poor.

Ms. Pollitz. Yes.

Mr. Boyle. We are not talking about people who are sitting at home and doing nothing. These are often people with full time jobs, but don't make -- or make a little bit too much money to qualify for traditional Medicaid, but not nearly enough to afford healthcare.

Ms. Pollitz. Right. And actually for working poor adults, even -- well, if they weren't working and they didn't earn anything, they weren't eligible for Medicaid before. But most of the expansion population, as you pointed out, they are working people. They are in minimum wage jobs and they are earning less than 138 percent of the poverty level, and they would lose coverage.

Mr. Boyle. I yield back. Thank you, Mr. Chairman.

Chairman Neal. I thank the gentleman. And, with that, I would like to recognize Mr. Kildee for the purpose of inquiry for 5 minutes.

Mr. Kildee. Thank you, Mr. Chairman, for recognizing me and for holding this very important hearing. This is obviously a subject that is one of the subjects that drew me, and I know a lot of the newer members to this committee, this is obviously quite critical, and the decisions we make have real impacts on real people.

Like a lot of families, like a lot of people, like a lot of the people that I represent, preexisting conditions and their impact on the ability to receive healthcare is really personal to me. Like a lot of the families I represent, like a lot of people around this country, I have close family members that have pretty significant preexisting conditions.

Twenty-one years ago my wife was diagnosed with multiple sclerosis. Thank God she has been able to receive good care, but I can't tell you how many times we have had the conversation about what our lives would be like if we were like so many other people in this country that have had to try to deal with these life-changing experiences, like Mr. Blackshear has gone through, without having the benefit of health insurance, and without

having the assurance that that condition will somehow prevent them from receiving important care.

Like my wife, I have a daughter who is 26 years old, who is a Type I diabetic, who was diagnosed when she was 7 years old. I can't tell you again how many times my wife and I had this conversation about what will happen when our daughter is gone from the nest. Will she ever be able to have a future? It is not just about being able to get healthcare.

So actually having the certainty that you can have aspirations, you can dream about your own future, that you can plan to be a productive and important part of society, that paw that hangs over people without that assurance affects our society in ways that I think we often don't even measure.

So any time there is a threat or an effort to undermine that very elegant guarantee that is embedded in the Affordable Care Act, we have to take notice. And assurances and pleading from folks on the other side who on one assure us that they want to protect those assurances, but support Federal litigation that would essentially take that away, is a threat to people like me and the people that I represent who have that same set of circumstances.

RPTR MOLNAR

EDTR SECKMAN

[1:19 p.m.]

Mr. Kildee. So family members that are able to purchase healthcare at an affordable price, regardless of their circumstances, it is pretty important. And I wonder, starting perhaps with Ms. Pollitz, if you could tell us what options would exist for people with preexisting conditions in terms of plan availability and cost -- I know this may be somewhat redundant, but it is important to put this down -- what options would be available if the administration's efforts to undermine the ACA were to succeed? Where could they go?

Ms. Pollitz. Before the ACA, Mr. Kildee, there was -- job lock was an issue, so people would maybe take a job or stay in a job that they would rather leave because of the health benefits. A friend of mine jokingly coined the term "slob lock" to relate to people who maybe stayed in marriages for the health insurance or got married for health insurance.

For young adults -- it sounds like our kids are about the same age -- young adults had the highest rate of uninsurance before the ACA because their birthday gift or their graduation gift was they lost eligibility for their parents' policy, for Medicaid. And if they couldn't afford coverage -- often they couldn't because they weren't making a lot of money yet -- then they would be uninsured. And certainly if they had a preexisting condition, like the ones you talked about, they would be uninsurable. So it is materially different now.

Mr. Kildee. Thank you.

Mr. Stolfi, would you comment?

Mr. Stolfi. Thank you, Representative. I can add two points to that. The

first -- and we saw this prior to the ACA -- if you were lucky enough to get an individual health plan, that pool of people, as they got older, they got sicker; insurance companies could decide that they no longer wanted to carry that block of people, that pool of people, and could discontinue an entire policy, therefore, presenting someone who might have developed health conditions with the option of taking another policy that insurer offered, which would surely have less benefits and more cost, or taking their chances to go through medical underwriting again, when, if they have developed a condition, it would surely be denied.

And another thing that happened quite a bit before the ACA, there was a lot of uncompensated care. Hospital systems in Oregon had hundreds of millions of dollars more uncompensated care, which drives up the cost for everyone else.

Mr. Kildee. Again, I thank you for your presence here. I thank the chairman for arranging this hearing. It is an important moment, and I yield back the balance of my time.

Chairman Neal. I thank the gentleman.

The gentleman from Texas, Mr. Arrington, is recognized to inquire for 5 minutes.

Mr. Arrington. Thank you, Mr. Chairman.

And to the ranking member, it is an honor to serve with you, and it is a great opportunity for rural America to have a seat at the table where a lot of the big problems that we face as a country are being worked out.

And in rural west Texas, I can tell you, the way we solve things is we start by agreeing on a set of facts. And then we agree on what success is; we define it so that we are all clear when we have achieved it. Otherwise, we wander in the wilderness. Because this issue is so highly charged and has been politicized and demagogued on both sides, let's, Ms. Pollitz, agree on some facts.

One fact may be that Kaiser is not bringing policy advice and recommendations, you are, no doubt, an organization that has expertise in healthcare policy information and analysis. Is that --

Ms. Pollitz. We try, yes.

Mr. Arrington. Would that be a true statement?

Ms. Pollitz. Yes.

Mr. Arrington. Would you agree that in the implementation and over the last several years of the ObamaCare ACA implementation, that the cost of care has gone up significantly? I use the word "exponential," but -- because premiums have doubled across the country. Would you say that because of the implementation and during the implementation, costs have gone up significantly, yes or no? Just yes or no, have costs gone up in healthcare since the implementation of ObamaCare?

Ms. Pollitz. Healthcare costs have gone up --

Mr. Arrington. Yes. Okay.

Ms. Pollitz. -- although --

Mr. Arrington. Second, choice been reduced? That is -- my understanding is 50 percent of the counties where my fellow Americans live only have one insurer. Has their choice in being covered by an insurance company and with a certain plan, has that been reduced since the implementation of ObamaCare, yes or no?

Ms. Pollitz. I don't believe so.

Mr. Arrington. Okay. Now let's talk about this notion that Republicans somehow don't support the provisions in the ACA that protect people with preexisting conditions. Did your organization review and analyze the American Health Care Act? That is the Republican reform bill that passed last year out of the House but failed in the Senate.

Ms. Pollitz. Yes, we did.

Mr. Arrington. And are you aware that we protected the ObamaCare provision regarding people with preexisting conditions and, in fact, sort of belted suspenders; we put a rule of construction in play that says: Nothing in this act shall be construed as permitting health insurance insurers to limit access to health coverage for individuals with preexisting conditions. Were you aware of that?

Ms. Pollitz. I was aware of that --

Mr. Arrington. Okay, so, yes.

Were you aware of that, Mr. Stolfi, that Republicans protected that provision of the ACA, because we believed it was important?

Mr. Stolfi. I was aware of that language.

Mr. Arrington. Yeah, were you aware of that, Mr. Robertson?

Mr. Robertson. Yes.

Mr. Arrington. Were you aware of that?

Ms. Brooks-Coley. Yes.

Mr. Arrington. Were you aware of that?

You are all aware of it. So this could be a really short hearing, Mr. Chairman. We are all in favor of preexisting conditions.

Now let's get on to the real business of solving the problem, and in order to do that, like I said, you have to define what success is.

Mr. Stolfi, is there a difference between being covered by health insurance and having access to affordable care? Is there a difference?

Mr. Stolfi. There is a --

Mr. Arrington. Yes or no?

Mr. Stolfi. Between having insurance and healthcare? Yes.

Mr. Arrington. Okay. Does everybody on the panel agree with that, that there is

a difference between being covered, or having a health insurance card and having access to affordable care? So would the real definition of success for this committee and your sort of advice to us, as people representing our fellow Americans, be that we focus on how we make healthcare affordable for the American people, especially our working and middle-income families? Would you agree? Just nod yes if you do.

Mr. Arrington. So, Commissioner Stolfi, let me ask you a few questions about your State in particular. You said that there were 300,000 new, newly insured people since the ACA's implementation, correct?

Mr. Stolfi. About 350,000.

Mr. Arrington. How many of those got care through the exchange, of the 300,000, versus Medicaid expansion?

Mr. Stolfi. Majority of the additional --

Mr. Arrington. The Medicaid expansion. All right. I am not going to try to play games with you here. I am just going to state the fact -- and you can confirm or deny -- that 400,000 people in your State, citizens, fellow -- what do you say?

Mr. Stolfi. Oregonians.

Mr. Arrington. -- Oregonians were qualified and eligible for the exchange. And two-thirds of the 400,000 decided not to get ObamaCare through the exchange. They decided to pay the fine rather than to get care on the exchange. Is that correct?

Mr. Stolfi. I am not certain of those numbers, no, sir.

Mr. Arrington. I yield back, Mr. Chairman.

Chairman Neal. I thank the gentleman. I would say in reference to the gentleman's point, the chair never assumed that this would be a short meeting.

With that, let me recognize the gentleman from Virginia to inquire, Mr. Beyer.

Mr. Beyer. Mr. Chairman, thank you very much. Mr. Chair, I would like to point

out that I have been running the family business for 45 years, and our healthcare premiums were going up 15 percent per year before ObamaCare. And if you do the math, that means a doubling in 5 years. So this -- a part of what ObamaCare was designed to address was the fact that premiums were going up very quickly before. In fact, ours did not go up any faster after ObamaCare than before, despite the fact that coverage was so much greater.

Mr. Chairman, without objection, I have four letters I would like to submit to the record and just briefly describe them.

Chairman Neal. Without objection.

[The information follows:]

Mr. Beyer. The first was -- I was one of many Members of the House that wrote Speaker Ryan on November 1, 2017, about the President's decision to end cost-sharing reductions. We have heard so much about the costs of healthcare. Ending the cost-share reductions, which were an integral part of ObamaCare, the Affordable Care Act, certainly increased the cost for premiums.

The second was a letter on May 31, 2018, again, many Members of the House, to President Trump, about his signing H.R. 1 that functionally eliminated the provision that required Americans to purchase health insurance. I believe, Mr. Robertson, in your explanation of how the association has reduced costs, you said the larger the risk pool, the better.

Well, the very core of the Affordable Care Act is we have the largest risk pool possible, and that is what the mandate did. And when the Republican leadership and the President eliminated that mandate, obviously we pushed costs up for everyone. We took those low-cost young people out of the health insurance pool. That is the way insurance works, going back a thousand years.

The third letter, two versions, October 30, 2018, both to the Attorney General and to the President, about the Justice Department refusing to intervene in the lawsuit brought by State attorneys general that would nullify preexisting conditions protection.

If my friends on the other side are so committed to the protection of the preexisting condition waiver, the first thing we should do is get the Department of Justice and our President to stop the lawsuit that would make it irrelevant.

All of these, by the way, Mr. Chairman, contribute to the uncertainty that pushes up premiums. Every time we mess with the Affordable Care Act and do something yet again to undermine it, we are making premiums go up.

But, Ms. Pollitz, I have a specific concern for you. Because I have heard a number

of times the quote that nothing in this act shall override the ObamaCare protection for preexisting conditions. Isn't there also a provision in the act that allows States to apply for a waiver to get rid of the preexisting condition?

Ms. Pollitz. There was, yes, a provision to allow States to waive the community rating requirements so that people could be charged more based on health status.

Mr. Beyer. Isn't that functionally the same? When you don't waive preexisting condition, you just make it unaffordable; is it not virtually the same thing?

Ms. Pollitz. Well, that would have made it harder for people with preexisting conditions to afford coverage.

Mr. Beyer. Like a Mr. Blackshear or like so many members of our family members that we talked about here today.

Ms. Pollitz. Yes.

Mr. Beyer, that law also substantially changed the subsidies, turning them into flat tax credits and smaller tax credits so that they would not have had the same stabilizing effect. And to the extent that people did drop out of coverage, which CBO estimated tens of millions of people would lose coverage, that would drive up premiums for people, to the extent that people with preexisting conditions stayed, and the tax credits would no longer protect them from that tax increase -- from that premium increase.

Mr. Beyer. Seems like most of the adjustments made in the last few years have been to increase the number of people with adverse selection being part of the insurance pool and reduce the ones that would bring the costs down.

So we talked about pregnancy as a preexisting condition. Maybe anyone would like to comment on the fact that because of the Affordable Care Act and the pregnancy prevention coverage, the contraception coverage, one of the few things we can agree on here -- the pro -- anti-choice versus pro-choice, a woman's reproductive rights -- that our

abortion rate is the lowest it has been since Roe v. Wade, and that there are fewer teen pregnancies and unintended pregnancies than there have been in decades. Ms. Pollitz, as a researcher?

Ms. Pollitz. Yes. And access to contraceptive coverage has helped. Actually, I was not able to answer the Congresswoman's question before, but now only about 2 percent of young women end up having to pay out-of-pocket costs for a contraceptive. It was much higher before the ACA.

Mr. Beyer. And, Ms. Brooks-Coley, now that we have this waiver of preexisting condition, the protections, have you seen any difference in cancer survival rates, when people are not thrown off insurance because they have cancer or can't get insurance?

Ms. Brooks-Coley. We do have -- Congressman, thank you for the question. We do have evidence to show that individuals who receive a cancer diagnosis, their cancer is being detected earlier, and we know that their survival rates and treatment outcomes are better because they have access to coverage earlier than they did pre the Affordable Care Act passing.

Mr. Beyer. Thank you very much.

Mr. Chair, I yield back.

Chairman Neal. I thank the gentleman.

The gentleman from Pennsylvania, Mr. Evans, is recognized for 5 minutes to inquire.

Mr. Evans. Thank you, Mr. Chairman.

I would like to follow up with Mr. Arrington's statement and allow you, Ms. Pollitz and Mr. Stolfi, to respond to what I think you wanted to say, wanted to add a little bit more addition. That is the impression I got. So you had your opportunity, both of them, to kind of give some response in terms of protecting people with preexisting condition. So

whoever wants to start.

Ms. Pollitz. Well, I guess in response to the question about rising premiums versus rising costs, the national health expenditure data show that actually healthcare costs per capita have risen at a lower rate since the enactment of the ACA.

In the 1990s, the average annual rate of increase in per-capita healthcare costs was about 5 percent. In the 2000s, it was 6 percent, and since the ACA, it has been 4 percent. So, still rising, but at a slower rate, kind of a bend in the curve. And we see similar kind of changes in the rate of out-of-pocket per-capita spending since the enactment of the ACA.

Mr. Evans. Commissioner?

Mr. Stolfi. Thank you, Representative Evans. I could just add to that to follow also what Representative Beyer said about costs rising, this is not a new phenomenon. In the individual market in Oregon before the Affordable Care Act, in 2008 and 2009, we saw rate increases that were greater than the rate increases we saw in 2018 and 2019. There was 21 percent and 17 percent, if I got those numbers correct.

So this is not a new phenomenon, but also as Representative Beyer pointed out, the products are fundamentally different. So the products that people have now, the protections that individuals have now are much more comprehensive and worth much more than they were before the Affordable Care Act.

Mr. Evans. So, in other words, they weren't protected then?

Mr. Stolfi. Much less so than they are now.

Mr. Evans. Okay. Mr. Chairman, being that I am new to this committee but obviously not new to life, the President of the United States came to Philadelphia August of 2016, and this is the exact quote he said. He was specifically talking to the black community. He said: What the hell do you have to lose?

The reason I asked the question is, in the past 2 years, the Trump administration has drastically underfunded outreach and education initiatives. What I am interested in, could you please discuss the linkage between risk pools, outreach, and health disparities? Can you respond to that aspect?

Ms. Pollitz. I think -- we still have a continuing health disparities problem due to many factors. But it is also true that extending coverage does help and address that because it gives more people at least a ticket to healthcare. They may encounter other barriers after that, but we have seen -- we have seen dramatic increase -- or decreases, rather, in uninsured rates, particularly among minorities, and so that has a positive effect in improving access to care.

Mr. Evans. So minorities have something to lose?

Ms. Pollitz. Yes.

Mr. Evans. Okay. Do you want to comment on that?

Mr. Stolfi. Representative Evans, I could just add to that, that every healthcare consumer is different. Every individual has different healthcare needs, different healthcare IQ, different biases, as one Representative noted earlier. And the best way to help each individual is to have one-on-one counseling, one-on-one education, and that costs money. And States like Oregon do spend quite a bit of money training advocators, training people to educate and help consumers. It is unfortunate when there are cuts to programs such like that.

Mr. Evans. Mrs. Brooks-Coley, do you have any comment on that?

Ms. Brooks-Coley. I do. Thank you, Congressman. I would just make the comment that, from a cancer perspective, racial and ethnic minorities continue to have higher cancer rates and are less likely to be diagnosed early. So access to coverage and access to comprehensive coverage is extremely important for that population of

individuals.

Mr. Evans. I am going to go to Ms. Pollitz real quick. There was a report in 2017 coming from your organization that said changes insurer participation in Affordable Care Act relating -- was somewhat down. The question I want to ask you, can you explain to us how premium tax credits assist in keeping healthcare affordable and also help to stabilize the insurance risk pool?

Ms. Pollitz. Yeah. So premium tax credits are set on a formula so that you, as an individual, pay only a certain dollar amount toward the benchmark plan. If you are at the poverty level, that is about $20 a month. If you are at 150 percent of the poverty level, that is about $60 a month. That is what you pay, and the difference between that and whatever the benchmark plan is, is the dollar value of your tax credit.

So, if premiums go up $100 next year and I am at 150 percent of poverty, I paid $60 for the benchmark plan last year; I pay $60 for the benchmark plan this year.

The tax credits also help really cure a lot of adverse selection. Normally, if -- especially a low-income person, I would have to really ask some hard questions. Can I afford the $60? I need a car payment. I am healthy. Maybe I will skip the insurance because I need to spend the money somewhere else. So the subsidies help people when they sort of evaluate the expected cost of care and the cost of insurance. They help kind of bring that calculation in line, so that people are much more likely to sign up and stay signed up as long as they are protected from the full cost of insurance.

Chairman Neal. We thank the witness.

With that, let me recognize the gentleman from Georgia to inquire, Mr. Ferguson, for 5 minutes.

Mr. Ferguson. Thank you, Mr. Chairman, and I am very grateful to be having this hearing. Let me say to each of you: Thank you for taking time out of your busy

schedules and your personal lives to come here and talk about this important topic.

I think it is important that we set that we are doing exactly what we are doing today, which is to set the record straight on preexisting conditions, both our past positions, our current positions, and our future positions. And one of the things that I think that -- a rubicon that we have crossed in this country is that we all recognize -- Republicans and Democrats, Independents; it does not matter -- we all believe that our fellow Americans should be covered.

I don't think that there is an argument there, and I think that every one of us believes that in our heart. I think a lot of the argument is about how do we do that. Okay? I think to simply say that "if you are against the Affordable Care Act, that you are against preexisting conditions" is not being intellectually honest, particularly with the American people.

You can be for preexisting conditions and be against the Affordable Care Act for other reasons, and that is pretty much the position I am in.

Listen, as a former healthcare provider, I used to fight this battle with insurance companies when I would have a patient that would come in with a preexisting condition, that they said would not be covered, yet they were willing to spend countless dollars on another condition that was created by, in fact, this existing condition. It made absolutely no sense. And we had to go to battle for our patients on a regular basis. And this is in the pre-ACA days.

So there have been a lot of comments about what we had before didn't work. True. What we have now is not working because one of the challenges that we have had is that we have seen real costs rise to everyday Americans.

You know, you made the comment, Ms. Pollitz, that rates are rising at a lower -- at a slower rate. Healthcare --

Ms. Pollitz. Healthcare costs, not premiums, yeah.

Mr. Ferguson. So, you know, if you would like to come down to the Third District of Georgia and stand on stage and make that comment, I will let you do it by yourself. Because you might have some stuff other than words thrown at you. And my point in saying that is, is I think that in many parts of the country, that is not the case. I mean, we have got constituents that have seen premiums go from $600 a month with a $1,000 deductible to $2,400 a month with a $6,000 deductible.

I have got a single mom, former patient of mine, two teenage girls, that simply cannot afford to go to the doctor on her insurance plan.

So I think the thing that we want to get out of all of this today and I think the real honest conversation that we have is, number one, recognize that we all believe that our fellow Americans, and particularly those that are most vulnerable, should have access to affordable care, and they should have access to affordable insurance. I think it is wrong to state otherwise.

I also think that we need to come together, as a Congress and as a Nation, to discuss how to drive down the actual cost of care. One of the things that I worry about greatly, in all of this, and one of the unintended consequences, or maybe the intended consequence, of the ACA is that you are now seeing a very rapid, vertical integration of the healthcare delivery space. You look at the different players that are in that market, and they are all joining hands. And it is becoming fewer and fewer players in the marketplace, and there is less competition.

One of the things that I am excited that Mr. Robertson has brought is a competitive idea that gives the consumer a different choice. So to say that we can't have competition in the marketplace or we won't be able to cover our most vulnerable, I think, is wrong. I think we are a talented enough group of Americans that we can figure out how to do that.

And let's be honest about the fact that we all believe in care for our most vulnerable and those with preexisting conditions. But we can all band together to fight to drive down the rising costs of healthcare and health insurance so that people can actually take better care of themselves and their families.

And, with that, Mr. Chairman, I yield back.

Chairman Neal. I thank the gentleman. I thank the gentleman for his inquiry.

With that, let me recognize the gentleman from Illinois to inquire for 5 minutes, my friend, Mr. Schneider.

Mr. Schneider. Thank you, Mr. Chairman, and I want to thank the witnesses first for being here today and sharing your perspectives and insights but also for your patience. I know it is been a long day, but it is a critically important issue.

And I think what we have been talking about on this panel and others have said, but it is worth repeating, is we all need to be striving -- in the richest country in the world, everyone in this country should have quality affordable care, where they are, where they live, when they need it. And healthcare is not something -- I heard in a different meeting this morning, someone made the comment about Congress as we try to tackle long-term problems in 2-year cycles, and it is difficult.

Healthcare is not just a long-term issue; it is a lifetime issue for each and every one of us. And it starts at birth, but it is something we deal with our entire life.

And one of the things we have seen is that since the Affordable Care Act -- Ms. Pollitz, you touched on -- the cost of healthcare, of delivery, has not risen at the same rate it was before then.

And, with that, Mr. Chairman, I would like to submit for the record a report from the Commonwealth Fund, highlighting how ACA reforms have moved to paying for value and beginning to address the healthcare costs.

Chairman Neal. Without objection, so ordered.

[The information follows:]

Mr. Schneider. Thank you. And we are here today; it is a critically important topic, talking about protection for people with preexisting conditions. And as I have sat here today listening, but also over the course of the year, meeting with people, I am reminded of many young people I have met. I think of Jared Cooper, who was diagnosed at a young age with type 1 diabetes and has become a champion, and all the other kids I have met with diabetes, a lifetime condition, that, with treatment, hopefully they will be able to have a full and productive life.

A young woman, Kendall, who I met her when she was in seventh grade, but she was diagnosed when she was 2 years old with leukemia, and -- burden on the family, but she survived, will always be a cancer survivor. But when I met her -- and I saw her recently. She is now in ninth grade. This is a young woman who is on the soccer team, was a swimmer. She is living the life we hope for all of our children, reaching her full potential.

I met a young woman yesterday, Brie, who was brave enough to share with me her experience of dealing with learning disabilities, combined with ADHD, which can be a preexisting condition that would affect her outcomes, but with the proper treatment, she is going to have all the opportunities we all want for our children.

And it is not just young people. Mr. Blackshear, thank you for sharing your story and bravely sharing your story. I can only imagine what you went through, and it starts with just a drive through the desert. You know, you wake up the next day, and your life is changed forever. But that diagnosis shouldn't be a sentence of financial challenge. It should be something that you have the opportunity to consistently pursue -- and it looks like you might want to say something.

Mr. Blackshear. I was just going to say: I agree.

Mr. Schneider. But it is not just that, and these are things, I think all of us have

experience with preexisting conditions. My sister is a thyroid cancer survivor, mother of three young children, and doing quite well, but she will be dealing with healthcare issues her entire life. My cousin is a breast cancer survivor. My great nephew was born 2 months prematurely; he will soon celebrate his second birthday.

These are all things about our healthcare system that make the world possible for us to appreciate. They should be open to everybody. So I didn't mean to give a speech. I really wanted to get to a question, and, Ms. Pollitz, I will start with you. I just gave a list of friends, neighbors, family, with preexisting conditions. If we were to lose the protections for these people, broadly speaking, what is the impact, not just on these individuals but on our community?

Ms. Pollitz. It would make it harder for people, as hard as it was before the ACA, to get and stay affordably covered. It would just make it harder for people. People, before the ACA, sometimes hit bottom and did without, and -- so they couldn't get treatment for those conditions. Sometimes they had to rearrange their lives in extraordinary ways, move or take a job or marry or change their income or, you know, do something extraordinary in order to be able to stay attached to some other coverage for which they were eligible that wouldn't discriminate based on their preexisting condition. So this makes other options possible for people.

Mr. Schneider. Thank you, and I just have a few seconds left. But, Mr. Blackshear, you were 27 when you were diagnosed with Valley Fever --

Mr. Blackshear. Correct.

Mr. Schneider. -- right? And you said that was a couple years ago. I think you shared with us, you have healthcare now; it is not a worry. And as you look to your future, is it something that you feel you can count on, or is it something that still hangs over your head, saying, you know, I don't know if I will have it a year or 5 years from

now?

Mr. Blackshear. I really do hope I can count on it. I really do. The conversations we are having, you know, I wish we were past this, you know, but they are very important, and I really do hope so.

Mr. Schneider. Thank you. I hope so, too. I am out of time. I will just say this: It has been 10 years we have been litigating the Affordable Care Act while healthcare has moved forward. Our job as policymakers, I would like to say -- is we don't get to be ahead of the curve; we have to do everything we can to catch up and stay in pace with healthcare -- but our job is to make sure, Mr. Blackshear, that you don't have to worry about this and you can achieve your dreams. Thank you and I yield back.

Mr. Blackshear. I appreciate it. Thank you.

Chairman Neal. I thank the gentleman.

And, with that, let me recognize the gentleman from California, Mr. Panetta, to inquire for 5 minutes.

Mr. Panetta. Thank you, Mr. Chairman. I appreciate this opportunity and appreciate this type of hearing on such an important topic such as preexisting conditions. Let me also thank all of the witnesses at this point for being here and your endurance this morning and this afternoon.

But I want to give four of you a break and actually focus on Mr. Stolfi and have a conversation with you, if that is okay. So the rest of you can either zone out or just take a little break.

I want to talk about the connections between preexisting condition protections and the ACA. Okay? I think what you are hearing today is that most of us support the protections of preexisting conditions. But I think what we need to highlight is what exactly people are doing to support it, and that it is not necessarily intellectually dishonest.

What it is, is an actual contradiction. What it is, is an actual inconsistency, which I think is something that all of us, as representatives of the people, try to avoid, being inconsistent. We want to be consistent.

But it seems that in some of my colleagues' support for a couple things, there is some inconsistency. And starting with the Texas v. Azar case, a case that was filed to strike down all of the ACA, in that you had 20 Republican attorneys general who basically wanted to repeal the individual mandate as part of the tax law, if what they were arguing because it was zeroed out in such that the mandate was no longer constitutional.

And then, on top of that, you had our administration, this administration, through the Department of Justice, file a separate brief during that case in which they decided not to defend the constitutionality of the individual mandate, and they agreed that certain provisions of the ACA -- guaranteed issue, community rating, the ban on preexisting condition exclusions, and discrimination based on health status -- are inseverable, are inseverable, from that mandate.

Now, to me, supporting the DOJ brief, supporting that case by the 20 Republican AGs, seems inconsistent with saying you are then for preexisting conditions protections. Am I correct?

Mr. Stolfi. I would agree that it would be inconsistent to support protecting people with preexisting conditions and the Texas lawsuit at the same time.

Mr. Panetta. And why is that?

Mr. Stolfi. Well, the Texas lawsuit itself is seeking to invalidate and dismantle the entire Affordable Care Act.

Mr. Panetta. And that includes protection of preexisting conditions?

Mr. Stolfi. Absolutely.

Mr. Panetta. Now, what we are also seeing recently is certain States are trying to

create their own laws, saying: We protect preexisting conditions.

And I will use Wisconsin as an example. But what they are doing, though, in trying to protect preexisting conditions, how is that possible -- how is that possible without the ACA? Can you explain that?

Mr. Stolfi. Well, for one very big reason it would be rather difficult without the ACA, because the ACA, one of the essential elements of it are the subsidies it provides to individuals to afford the insurance that they need to have.

Mr. Panetta. Would it also create unbalanced risk pools?

Mr. Stolfi. Without the ACA, yes.

Mr. Panetta. And would it also -- I mean, it is basically -- it wouldn't ensure that certain procedures are covered as well, correct?

Mr. Stolfi. That would be likely, yes.

Mr. Panetta. As well as -- and what about the exclusions on annual or lifetime caps?

Mr. Stolfi. Those would go away in most States, yes.

Mr. Panetta. Exactly. So it would be pretty hard to support preexisting conditions without supporting the Affordable Care Act, correct?

Mr. Stolfi. It would be difficult, yes.

Mr. Panetta. Thank you, Mr. Stolfi.

I yield back. Thank you, Mr. Chairman.

Chairman Neal. I thank the gentleman.

Once again acknowledging the Gibbons rule. When the gavel came down, Mr. Suozzi had been seated, so we will move to him for 5 minutes for inquiry.

Mr. Suozzi?

Mr. Suozzi. Thank you, Mr. Chairman. I first want to thank you for holding this

hearing and thank you again for making clear to the Ways and Means Committee that you are going to be spending a lot of time on hearings looking at the facts of different issues. I think it is a great practice that you are making sure we return to. I saw Mr. Reed privately a few moments ago. I was hoping he would be here so I could say publicly that I want to congratulate him because he stated in his very strong comments earlier, that he gets it now. He finally gets the fact -- and the Republicans that he associates with -- they get it, that preexisting conditions must be protected. They heard the message. It only took years. It only took 70 votes. It only took hundreds of millions of dollars of campaign commercials. It only took billions of dollars of free air time debating these issues. But they finally get the fact that we must protect preexisting conditions. I think that is an excellent, excellent result.

Ms. Pollitz, I know you that said earlier that you don't advocate for policy; you just focus on the facts and what is out there, the data. So I wanted to just confirm some things with you. Of the 330 million people in America, 160 million to 175 million are covered by their private employer for their health insurance.

Ms. Pollitz. Correct.

Mr. Suozzi. And about 75 million by Medicaid; 45 million by Medicare; 30 million remain uninsured, 4 million people more than it was before this administration took office. Is that correct?

Ms. Pollitz. I don't know that the number of uninsured has risen quite 4 million in the last 2 years, but it has started to tick up again.

Mr. Suozzi. Any idea of what that number would be, of how many it has gone up by? It is okay. You don't --

Ms. Pollitz. I will have to submit a number for you.

Mr. Suozzi. And there are about 23 million people that are covered in the

individual marketplace?

Ms. Pollitz. Not that many. It is closer to 15 million that are in the individual marketplace.

Mr. Suozzi. Okay.

Ms. Pollitz. I am sorry. In the individual market, most of them in the marketplace.

Mr. Suozzi. Is 15 million?

Ms. Pollitz. Total, for the individual market, yes.

Mr. Suozzi. So most of the stories that we hear about insurers pulling out of the market and about premiums going up dramatically, are most of those stories specifically related to the individual market?

Ms. Pollitz. Yes.

Mr. Suozzi. So most of the dissatisfaction with what is going on in the marketplace is directly related to the individual market?

Ms. Pollitz. Correct. And that rise in premiums that was on the chart before, that is just for the individual market. We don't see that same volatility in the cost of employer plans.

Mr. Suozzi. So you are referring to Mr. Rice's questioning earlier when he had the charts up, about -- he said only 6.6 percent more people were covered. That happens to be 20 million people, which is an awful lot of people whose lives are much more improved that they have access to healthcare, and it is a humongous number of people, especially if you are one of those 20 million people.

Ms. Pollitz. Yes.

Mr. Suozzi. But when he talked about the rising of the rates in the individual market, much of those rate increases would have existed anyway because rates were going

up anyway before the Affordable Care Act. Of course, they were affected by the Affordable Care Act as well, but weren't rates going up anyway?

Ms. Pollitz. They were, but the rates weren't the same for everybody. So people, as long as they were healthy, could kind of move to another plan, resubmit to medical underwriting, maybe get another cheap rate. But as soon as you got sick, either your rates would go off through the roof or you would get locked out of that market altogether.

Mr. Suozzi. So one of the things that we have discussed here today is that the administration has been pushing these short-term plans. And these short-term plans are, in fact, cheaper for the people who are buying these short-term plans, but one of the reasons they are cheaper is they don't cover preexisting conditions. Is that correct?

Ms. Pollitz. That is correct.

Mr. Suozzi. So one of the points that we are trying to make in this testimony today, or this hearing today, is that preexisting conditions, when they are not covered, may provide you with cheaper rates, but the people who have preexisting conditions are very seriously hurt by that and can't afford themselves of those particular plans?

Ms. Pollitz. That is right.

Mr. Suozzi. And I just wanted to clarify one thing that you -- I think it was you that said it earlier. You said that we have seen premiums increase over the past year, but we estimate that about 6 percent of the increases are due to, one, the repeal of the individual mandate, and, two, the okaying of short-term plans.

Ms. Pollitz. Actually, we saw the 2019 premiums go down a little bit this year, but if not -- by 1 percent, but if not for those two other factors, the repeal of the mandate and the expansion of short-term plans, we would have seen them go down another 6 percent. So insurers tell us in their rate filing that even though they kind of overshot the mark last year when they corrected and so they are kind of lowering their rates, that they are not

going as low as they would have otherwise because they are still worried about this other source of uncertainty.

Mr. Suozzi. Thank you very much. I yield back my time.

Chairman Neal. I thank the gentleman.

Let me recognize the gentlelady from the State of Florida, Mrs. Murphy, to inquire for 5 minutes.

Mrs. Murphy. Thank you, Mr. Chairman, and thank you to the witnesses for your testimonies.

Along with Congressman Buchanan, I am one of the two Members on this committee who represents Florida, and according to the Kaiser Family Foundation, there are an estimated 3.1 million people in Florida under the age of 65 who have a preexisting health condition, such as cancer or diabetes or heart disease. And I can sit here thinking to myself that I know at least one family member or friend who has some kind of preexisting condition, and I imagine that my constituents probably could do that as well.

And in fact, according to Kaiser, nearly 3 in 10 nonelderly adults in my Orlando-area district have a preexisting condition. That is one of the most of any major metropolitan area in all of Florida. It would have been very difficult, and maybe even impossible, for these constituents of mine to have obtained health insurance on the individual market prior to the passage of the Affordable Care Act in 2010 because of the way that the insurance companies screened applicants for coverage.

And the ACA, in addition to empowering States to expand Medicaid to more people and creating federally supported health insurance marketplaces for individuals and families, established robust protections for Americans with preexisting conditions within those marketplaces. Specifically, the law guaranteed access to insurance regardless of health status. It prohibited insurance companies from varying premiums based on

people's health and required coverage of certain essential benefits that are important to a healthy life.

And thanks to these consumer protections and to the availability of the Federal financial assistance for lower income individuals, there are now 1.7 million Floridians enrolled in a marketplace plan. That is far more than any other State.

And in other words, you know, despite the misguided decision not to expand Medicaid, Florida has benefited a great deal from the Affordable Care Act. The State and its citizens stand to lose a great deal if the law is repealed by Congress, struck down by the federal courts, or undermined by regulators at the Department of Health and Human Services.

Nonelderly adults with preexisting conditions could once again be denied coverage or charged an excessive amount for coverage. And while my colleagues on the other side of the aisle claim that they support protecting people with preexisting conditions, it is my understanding that few, if any, of the patient advocacy groups supported their various efforts to repeal and replace the Affordable Care Act.

If their proposals were even adequate at providing patient protections, why would the patient groups that purport to help, oppose them? You know, so my colleagues on the other side can say they support people with preexisting conditions all they want, but the reality is that they continue to support efforts to undermine these protections that Americans want. And I think it is well past time that they matched their words with actions.

So my question is for Ms. Pollitz. At the risk of asking you to repeat what you have already said many times today, can you explain in just very simple terms what the recent legislative, administrative, and judicial efforts to weaken the Affordable Care Act would mean for people with preexisting conditions in Florida and other States? And can

you really argue with a straight face that -- or can anyone really argue with a straight face that my constituents would be in a better position now if these efforts were successful?

Ms. Pollitz. So the -- I am sorry. The recent changes -- I won't go through them all -- have had the effect of increasing premiums artificially, for individual health insurance through the marketplace. When people are eligible for subsidies, they are protected from that. So it is the taxpayers of Florida who pay for that, not the insurance enrollees. But there are millions of people throughout the United States who aren't eligible for subsidies: They earn too much. They are in the family glitch that Keysha talked about. There are other reasons why they are not eligible. And they bear the full burden. So to the extent that they start to fall out of the marketplace, it is more likely that the healthier people will let go first, that the people who know they are using the coverage will hang on as hard as they can, find ways to hang in there, and that kind of drives up the cost more because it just means the average cost, the morbidity of the risk pool, increases.

So far the subsidies are kind of the stabilizing factor. They are kind of keeping it all together. They are keeping most of the people kind of covered in the marketplace. But at the margins, people with preexisting conditions are -- they are having to pay more for ACA coverage because they are not protected by the subsidies, and at some point, they may not be able to do that.

Mrs. Murphy. Thank you. I yield back.

Chairman Neal. I thank the gentle lady.

I recognize the gentleman from California to inquire for 5 minutes, Mr. Gomez.

Mr. Gomez. Mr. Chairman, thank you so much for organizing this important hearing. Healthcare is a very personal issue. For me, it was growing up without health insurance, spending 7 days in the hospital, when I was a kid, with pneumonia and almost bankrupting my family. Preexisting conditions don't just apply to seniors. They also

apply to little kids.

This individual I want to talk about is -- was about my age when she was diagnosed with a congenital heart disease. Her name is Micah. And I had a privilege of meeting her. She is amazing. She introduced herself as, first, a Girl Scout -- that is very important -- a figure skating aficionado, and a little lobbyist, because she was making her voice heard about the Affordable Care Act and what kind of impact it had on her life.

She might be just a kid, but her and her friends are really fighting to make sure the Affordable Care Act is in place. She has already had two open-heart surgeries and will need a third in the future. And without the ACA, she could lose her healthcare due to a serious preexisting condition.

And it doesn't only -- although they might be young, they are very aware of how their healthcare, their health, impacts their entire family. Because from that moment on, I knew that if I went outside to play, when I was a little kid, I got hurt, you know, it would have a big impact on my family because we didn't have healthcare coverage.

Micah and 130 million people with preexisting conditions deserve no less to have an honest conversation about the Affordable Care Act.

The other side of the aisle, I have been listening to them, and I must admit, I have been getting kind of, a little bit furious, a little hot under the collar here, because it is just -- all I could think about is whatever -- they don't understand that the Affordable Care Act works all together as all of you know, right? Every piece of it. When it comes to the subsidies, outreach, getting the risk pools, the marketplaces, the expanding of Medicaid, it all works together.

And it is like saying -- and when you don't fight for all of it, but you are saying you are for protecting people with preexisting conditions, it is not -- people who make that argument, I don't believe, are sincere. You know, the words I come up with when I hear

those arguments are hogwash, rubbish, blarney, and just plain nonsense.

You know, if you weren't at a hearing and somebody was making that argument, let's say, at your kitchen table, right, what would you say to them, that, "Oh, yeah, I am for preexisting conditions, but I am not for subsidies; I am not for anything else in the Affordable Care Act"? It is -- I would love to hear what you would say.

Ms. Brooks-Coley, what would you say?

Ms. Brooks-Coley. From the cancer perspective, we represent a population of people who, before the Affordable Care Act, could not access coverage. Oftentimes they were individuals who actually couldn't even get a plan even though they had a serious illness such as cancer. So, from our perspective, the entire ACA and that infrastructure is what has led to patients with serious illness, like cancer, to have access to coverage and agree with you that the patient protections, of course, which are center of the law and important to us from the serious illness perspective, but the entire law does work together to make sure people have better access.

Mr. Gomez. Mr. Stolfi, what would you say?

Mr. Stolfi. Thank you, Representative Gomez. I mean, to be honest, I think one of the most challenging things about this is how complex the issues are. And it is one of the reasons why this hearing is so important today, to talk in great detail and to make sure everyone fully understands what it means and all of the things that go into protecting people with preexisting conditions.

I mean, I am going to walk away today with, you know, a belief that there is a much greater understanding today, about what that is. And I think if I were sitting around the table with someone, I would spend quite a bit of time talking about some rather intricate, somewhat boring, insurance concepts in order to make sure they fully understood why every single part of it is important.

Mr. Gomez. And I appreciate that. And sometimes in life you just got to call out people for saying nonsense, right? And I know that they are probably sincere that they want to cover people with preexisting conditions, but we passed the Affordable Care Act to work as an overall structure. And now they are saying, after they basically ruined it, that the prices are coming up. So our job in the next Congress and moving forward is to fix what they broke.

Thank you, and I yield back.

Chairman Neal. I thank the gentleman.

And now to recognize the gentleman from Nevada, Mr. Horsford, to inquire for 5 minutes.

Mr. Horsford. Thank you very much, Mr. Chairman. Former Congressman Mo Udall once said: Everything has been said, but not everyone has said it.

So as the last member today, I am extremely thankful for this opportunity.

And thank you, Mr. Chairman. It says a lot that you made this issue of preexisting condition and the hearing today the first priority of this committee. So I want to thank you for that.

There are 371,000 Nevadans who would lose coverage in 2019 if the Affordable Care Act were repealed. Approximately 1.2 million Nevadans with private health coverage would lose guaranteed access to free preventative care like immunizations and cancer screenings.

The impact of the Affordable Care Act is critical. About one in two Nevadans, 51 percent, live with a preexisting condition, including myself. Because of the ACA, insurance companies can no longer deny coverage or charge more because of a preexisting condition.

One of those Nevadans is Joe Molino, who lives in north Las Vegas, Nevada. Joe

was diagnosed with a rare cancer in 2011, called chondrosarcoma of the larynx. On September 13, 2013, Joe underwent a 12-hour surgery to remove much of the tumor. He awoke with a tracheotomy, which he would have in for months.

The hole, his stoma, never healed, and he experienced a complication called tracheal stenosis, which impacted his ability to breathe. These complications kept him from going to work, and in February 2014, he was notified by his employer that his employee-sponsored healthcare would end. And he could not afford a COBRA plan on his disability payment.

Luckily, he was able to get coverage under Nevada's expanded Medicaid program, which I would note was actually approved by former Governor Brian Sandoval, the first Republican Governor in the country to adopt the Medicaid expansion in the country.

In 2016, with the help of the Medicaid expansion and the ACA health plan, he was finally able to get back to work and live a fulfilling life.

So I am committed, as my colleagues are on this side of the aisle, to do everything that I can to strengthen the Affordable Care Act. This is the central issue that the constituents in my district talked to me about over the last few years. So I am hopeful now with this new Congress that we will look at ways to build on the Affordable Care Act and make healthcare better for all Americans.

But, Ms. Pollitz, I would like to ask you, what are some of the improvements that Congress should be considering in order to improve affordability and access?

Ms. Pollitz. Well, again, Congressman, we don't make recommendations. I think there are a number of proposals that have been discussed in the course of today's session, including expanding subsidies for some or all people who aren't eligible for them today; expanding the cost-sharing subsidies so that they are more generous; other changes to ensure that the Medicaid expansion is available in every State, instead of, you know, just

the ones that have elected that so far.

So I think there have been -- and, you know, there are proposals to undo the Affordable Care Act and go in another direction. You know, the Better Healthcare Act is one direction. Others are talking about expanding public programs in other ways: Medicare, Medicaid eligibility.

So I think there are a lot of options on the table, and I am glad you are working on them.

Mr. Horsford. We will figure it out.

Ms. Pollitz. Thank you.

Mr. Horsford. Can you discuss why the end to annual and lifetime limits are important to cancer patients and other Americans facing complex healthcare needs, please?

Ms. Pollitz. Yeah. So there aren't that many people who would reach lifetime limits, but actually an old friend of mine who was on the board of the Nebraska high-risk pool got into it because he had two daughters born prematurely with severe congenital conditions, and he hit his million dollar lifetime limit on his policy with those girls in less than a year. So it does happen. They are the most severe conditions.

Cancer sometimes can get that high. My cancer treatment was never that big, but over a lifetime, it could get there. So that protection is there for the most extreme cases and the most costly cases, and it is a lifeline for those people.

Mr. Horsford. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Chairman Neal. Mr. Gomez has asked for a brief interlude here for a couple of seconds.

Mr. Gomez. Yeah. Mr. Chairman, I forgot to mention I would like to submit for the record a statement from Ricardo Lara, California's new insurance commissioner on this

issue. Thank you so much.

Chairman Neal. Without objection, so ordered.

[The information follows:]

Chairman Neal. Over the past decade, this dialogue has been, from time to time, pretty contentious. But today I heard a lot of Members on the other side of the aisle say they support protecting people with preexisting conditions. And I welcome this as an opportunity to move forward, and I hope that we can work together to make sure that we preserve these protections for all Americans, as they have come to rely upon them.

The witnesses today, all of you, you were exceptional. And I think that this is the sort of dialogue we could have going forward, based upon the testimony you have all offered. It was solution-based on how we can proceed in an area where people expect us to. So, I want to thank you for your testimony.

Please be advised that members have 2 weeks to submit written questions to be answered later in writing. Those questions and answers will be made part of the formal hearing record.

And, with that, the committee stands adjourned.

[Whereupon, at 2:14 p.m., the committee was adjourned.]

Submissions for the Record follow:

Kaiser Family

American Speech-Language-Hearing Association

Michael G. Bindner

Association for Community Affiliated Plans